

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---------|--|------------------|
| 01676 | | 01667 | |
| 1. DECEASED-NAME (Type or print) | | First | Middle |
| Harry | | Carlton | Aaron |
| 2a. DATE OF DEATH | | Month | Day |
| January 9 | | 1968 | |
| 2b. HOUR | | M | |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH |
| male | white | | March 7, 1896 |
| 6. AGE (In years last birthday) | | 7. AGE (In years last birthday) | |
| 71 YRS. | | 71 YRS. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Washington | | Washington | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | |
| Hagerstown | | 860 Frederick St. | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Supernision | | Railroad | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE | | 13b. COUNTY | |
| Md. | | Wash. | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Hagerstown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER | | 13f. STREET AND NUMBER | |
| 860 Frederick St. | | 860 Frederick St. | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | |
| John | | Katherine | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | | 16b. SOCIAL SECURITY NO. | |
| Yes | | 705-10-6076 | |
| 17. INFORMANT | | Address | |
| Mrs. Mary J. Aaron | | Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | |
| IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> | | Instantaneous | |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (myocardial infarction 1951) 16 1/2 yrs. | |
| (b) <u>Coronary Heart Disease</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | |
| 4201 | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| | | | |
| 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | |
| | | HOUR A.M. Month Day Year | |
| | | P.M. 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | |
| 21f. LOCATION | | City or Town | |
| Street or R.F.D. No. | | County | |
| | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>9-25, 1963</u> , to <u>1-9, 1968</u> , that (I) (we) last saw the deceased alive on <u>12/12/1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | |
| John H. Hornbaker, M.D. | | 1-10-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | |
| John H. Hornbaker, M.D. | | 154 West Washington St., Hagerstown, Md. 21740 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | |
| Burial | | 1-12-68 | |
| 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Rose Hill Cemetery | | Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | |
| Minnich Funeral Home Hagerstown, Md. | | DATE | |
| | | 25b. REGISTRAR'S SIGNATURE | |
| | | Charles Judge | |

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01237

RECEIVED
JAN 10 1964
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: DIRECTOR, AGRICULTURAL RESEARCH SERVICE
FROM: ASSISTANT SECRETARY FOR AGRICULTURAL RESEARCH
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]

6. [Illegible]
7. [Illegible]
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10. [Illegible]

11. [Illegible]
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16. [Illegible]
17. [Illegible]
18. [Illegible]
19. [Illegible]
20. [Illegible]

21. [Illegible]
22. [Illegible]
23. [Illegible]
24. [Illegible]
25. [Illegible]

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VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|---|---|---|---|--|--|-----|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01677 CERTIFICATE OF DEATH 01668 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Agnes Estella Ambrose | | | 2a. DATE OF DEATH Month Day Year January 14 1968 | | | 2b. HOUR 8:00PM | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH February 21, 1905 | | 6. AGE (In years last birthday) 62 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington | | | Md. |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.F.D. #2 Walnut Pt. Road | | 12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Walnut Pt. R.F.D. #2 Road | |
| 14. FATHER'S NAME First Middle Last Ezra Daniel Summers | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Gertie Virginia Houpt | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO. 217-58-3538 | | 17. INFORMANT George D. Ambrose Address Walnut Point Rd. Hagerstown, Md. R.F.D. 2 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of ovary 1830 DUE TO, OR AS A CONSEQUENCE OF With generalized abd. fluid 1 yr + Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1750 DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Asites, Hypertensive cardio. Ds - | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11 Jan 1968 to date , 19 68 , that (I) (we) last saw the deceased alive on 11 Jan 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard T. Binford, M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 15 Jan. 68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M.D. | | | | 22e. ADDRESS 1135 Potomac Avenue Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan. 17, '68 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash., Maryland | | | |
| 24. FUNERAL DIRECTOR Albert L. Leaf | | | | ADDRESS Williamsport, Md. | | 25a. REC'D BY REGISTRAR JAN 19 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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| | | | | | | | | | | | |
|--|--|---|--------------------------|---|------|---|--|--|-------------------|--------------|------|
| 01678 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01669 | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | | | |
| Durward | | | Grafton | Apple | | January 14, 1968 | | 7:00AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| Male | | White | | August 6, 1898 | | 69 YRS. | | 5 7 | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Maryland | | USA | | | | Washington | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Rural-Hagerstown | | 2414 Reedy Parkway | | Brakeman | | Railroad | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 2414 Reedy Parkway | | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| Walter Apple | | | | | | Eunice Norris | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | 218-14-0212 | | | Mr. Emanuel Apple | | | Williamsport, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>Arteriosclerotic cardiovascular</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic cardiovascular</u> (c) <u>Arteriosclerotic cardiovascular</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>year</u> | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Dissecting</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>29 June</u> , 19 <u>68</u> , to <u>date</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>10 Jan</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Richard T. Binford</u> | | 22c. DATE SIGNED 15 Jan. 68 | | 22d. PHYSICIAN'S NAME (Type) <u>1135-Potomac-Richard T. Binford, Md. 1135 Potomac Avenue Hag. Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | Jan. 16, 1968 | | Cedar Lawn Memorial Park | | Hagerstown, Washington, Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Albert L. Leaf | | | | Williamsport, Maryland | | DATE JAN 19 1968 | | <u>Charles Judge</u> | | | |

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January 14, 1958

January 14, 1958

January 14, 1958

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|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | | | | | |
| First Middle Last Robert H. Bachtell | | | | | Month Day Year January 22, 1968 | | | M | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | |
| Male | | White | | July 19 1876 | | 91 YRS. | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Maryland | | U.S.A. | | | | Washington | | Am Express | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 13a. STREET AND NUMBER | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| Boonsboro. | | Heeder's Nursing Home | | Laborer | | 125 N. Prospect St. | | | | | | | | |
| 13c. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13d. CITY OR TOWN | | 13e. STREET AND NUMBER | | 13f. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13g. STREET AND NUMBER | | | | | | |
| Maryland | | Washington | | Hagerstown | | | | 125 N. Prospect St. | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | |
| No Record | | | | | No Record | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | | | 16b. SOCIAL SECURITY NO. | | | | | 17. INFORMANT Address | | | | |
| No | | | | | 220-18-0693 | | | | | Mr James Resh 125 No Prospect St | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 Arteriosclerotic cardiovascular DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) with senility DUE TO, OR AS A CONSEQUENCE OF (c) 8922 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 4221 | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec 10, 1967 to Jan 22, 1968 , that (I) (we) last saw the deceased alive on Jan 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22g. REGISTRAR'S SIGNATURE | | | | |
| G.W. Van M.D. | | 1/23/68 | | G.W. Van M.D. | | Boonsboro, Md | | <input checked="" type="checkbox"/> | | 1/23/68 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE | | | | |
| Burial | | 1/24/68 | | Rose Hill Cemetery | | Hagerstown Wash Co Md | | JAN 29 1968 | | James Resh | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25. REC'D BY REGISTRAR | | | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Andrew K. Coffman | | | | | Hagerstown Md | | | | | James Resh | | | | |
| Coffman Funeral Home Inc | | | | | 125 N. Prospect St | | | | | Hagerstown Md | | | | |

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1997, 2000.

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11. *Journal of the American Medical Association*, 277, 1996, 1000-1001.

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1. The first group of people who are not in the labor force are those who are not in the labor force because they are not in the labor force.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|------------------------------------|--|---|--|--|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01680 | | | | | | | | | |
| 01671 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Ida | | | L. Baker | | | Month Day Year 1-10-68 | | | 11:05 PM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Female | | White | | 2/7/1875 | | | 92 YRS. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Payetteville #2 | | | U.S.A. | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | Garlock Convalescent | | | House Wife | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Pa. | | | Franklin | | Waynesboro | | | | 134 Cleveland Ave. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last William Butler | | | First Middle Last Margaret E. Kauffman | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 173-03-0206D | | Mrs. Howard H. Greenawalt, Waynesboro Pa. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Cardio Vascular Ds</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Smoking</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-13-1968, to 1-10-1968, that (I) (we) lost the deceased on 1-10-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>A. E. W. Little Jr</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/11/68 | | |
| 22d. PHYSICIAN'S NAME (Type) <u>A. E. W. Little Jr</u> | | | | | 22e. ADDRESS <u>213 W Washington Hagerstown Md</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/13/68 | | Green Hill | | Waynesboro, Franklin Pa. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | |
| Walter J. Grove | | | | | Waynesboro Pa. | | JAN 15 1968 | | Charles Judge |

010310

MINISTRY OF DEFENSE

010310

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| 97. NAME OF THE PARTY | | 98. NAME OF THE PARTY | |
| 99. NAME OF THE PARTY | | 100. NAME OF THE PARTY | |

010310

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01681

016722

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN lb LIFE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARTIN MANOR NURSING HOME | | d. STREET ADDRESS 736 INTERVALE RD. | |
| 3. NAME OF DECEASED (Type or print) JOSEPH WILLIAM BAKER | | 4. DATE OF DEATH Month JANUARY Day 28 Year 1968 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 12/18/1889 |
| 9. AGE (In years last birthday) yrs. 78 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SHEET METAL WORKER | | 10b. INDUSTRY SPRING BLAST MFG. | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME JOSEPH A. BAKER | | 14. MOTHER'S MAIDEN NAME WILLANNA K. JONES | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT MRS. VIVIAN TURNER | | HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) atherosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4500 (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH years | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia (Lobar) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1/28 , 19 68 , to 1/25 , 19 68 , that (I) (we) least saw the deceased alive on 1/28 , 19 68 , and that death occurred at 5:00 P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE A. M. Mandell | | 22b. DATE SIGNED 1/21/68 | |
| 22c. PHYSICIAN'S NAME (Type) A. M. MANDELL, M.D. | | 22d. ADDRESS 301 E. ANTIETAM ST. HAGERSTOWN, | |
| 23a. BURIAL, CREMATION, REBURY (Type) BURIAL | 23b. DATE THEREOF 1/31/68 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. |
| 24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE FEB 1 1968 | |
| | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|--|--|--|----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| NODA VIRGINIA BAKER | | | | | | JAN Month 1 Day 1968 Year | | | 2:00P |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| FEMALE | | WHITE | | SEPT. 20 1888 | | | 79 YRS. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| HAGERSTOWN | | | 1143 SUNNYSIDE DRIVE | | | HOMEMAKER | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | WASHINGTON | | HAGERSTOWN | | | 1143 SUNNYSIDE DRIVE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| WILLIAM C RUTH | | | MARY ELLEN SPRECHER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| NO | | | NONE | | GUY W BAKER 1143 SUNNYSIDE DR HAGERSTOWN MD | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u> | | | | | | | | | 5 years |
| 4129 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County State |
| | | | | | | | | | |
| 22a. I certify that (I) (if not <u>not</u> not <u>not</u>) attended the deceased from <u>1/6/67</u> , 19 <u>67</u> , to <u>1/1/68</u> , 19 <u>68</u> , that (I) (we <u>we</u>) lost saw the deceased alive on <u>1/1/68</u> , 19 <u>68</u> , and that in (my) (our <u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (we <u>we</u>) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| | | | | | | | 1/2/68 | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| E.W. DITTO JR M.D. | | | | 215 W WASHINGTON ST HAGERSTOWN MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | 1/4/68 | | ROSE HILL CEMETERY | | | HAGERSTOWN WASHINGTON MD. | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | HAGERSTOWN MARYLAND | | JAN 11 1968 | | | |

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30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|---------|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| Isaac | | | William | Barnum | Jan | Month | 16 | Day | 1968 |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS |
| Male | | | Colored | | Aug 8 1888 | | 79 | | IF UNDER 24 HRS. HOURS |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| St. James Md. | | | USA | | | | Washington | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown Md. | | | 147 W. Washington St. | | | Piperfitter | | | Railroad |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Washington | | Hagerstown | | | | 58 W. Bethel Street |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| William | | | Barnum | Letitia | Warfield | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | | 705-10-7428 | | Mrs. Carrie E. Barnum 58 W. Bethel St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> | | | | | | | | | 10 min |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic Heart Disease</u> | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized Arteriosclerosis</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4200 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/16/1966</u> , to <u>1/16/1968</u> , that (I) (we) last saw the deceased alive on <u>1/16/1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE, SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | |
| Robert H Campbell MD | | | 1/19/68 | | | Robert H Campbell | | | |
| 22e. ADDRESS | | | 22f. ADDRESS | | | | | | |
| Hagerstown Md. | | | Hagerstown Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | Jan 20 1968 | | Rose Hill Cemetery | | Hagerstown Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John K Watson Jr. Hagerstown, Md. | | | | | JAN 22 1968 | | Charles Judge | | |

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| 01684 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01675 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | Month Day Year | | | | | | | | | | Hour Min | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ruth Jane Barr | | | | | | | | | | Jan. 30 1968 | | | | | | | | | | 1:20 P | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| Female | | | | | | | | | | White | | | | | | | | | | Oct. 12, 1893 | | | | | | | | | | 74 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hagerstown | | | | | | | | | | Avalon Manor Nursing Home | | | | | | | | | | Hand Finisher | | | | | | | | | | Dry Cleaner | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Md. | | | | | | | | | | Washington | | | | | | | | | | Chewsville | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | -- | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Denton C. Frey | | | | | | | | | | Sallie - Oswald | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| no | | | | | | | | | | 214-09-4862-A | | | | | | | | | | Samuel W. Haines Jr., Box 15, Chewsville, Md | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4339 | | | | | | | | | | Cerebral thrombosis | | | | | | | | | | 10 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) Cerebral Arteriosclerosis | | | | | | | | | | 3 yrs. + | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) Generalized Arteriosclerosis | | | | | | | | | | | | | | | | | | | | yrs. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 332x | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 20, 1967, to Jan 30, 1968, that (I) (we) last saw the deceased alive on Jan 30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Lloyd A. Hoffmann | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 1/31/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffmann | | | | | | | | | | 22e. ADDRESS 214 N. Potomac St. Wash. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE Feb. 2, 1968 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home | | | | | | | | | | ADDRESS Smithsburg, Md. | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE FEB 5 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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[Faint bleed-through from reverse side]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Wilmer OWEN Bowie</i> | | | | | | 2a. DATE OF DEATH Month <i>January</i> Day <i>21</i> Year <i>1968</i> | | | 2b. HOUR <i>2:15</i> M | | |
| 3. SEX <i>M</i> | | 4. RACE <i>Negro</i> | | 5. DATE OF BIRTH <i>4/18/15</i> | | 6. AGE (In years lost birthday) <i>52</i> YRS. | | IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> | | IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>Maryland</i> | | | | 13b. COUNTY <i>FREDERICK</i> | | 13c. CITY OR TOWN <i>FREDERICK</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>162 W. ON SAINTS STREET</i> | |
| 14. FATHER'S NAME First <i>Roy</i> Middle <i>Emory</i> Last <i>Bowie</i> | | | | 15. MOTHER'S MAIDEN NAME First <i>Margaret</i> Middle <i>Susan</i> Last <i>Diggs</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. <i>220-05-6529</i> | | 17. INFORMANT Address <i>Margaret Bowie 164 W. Saints Fred</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMATOSIS</i> <i>185X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>CARCINOMA of prostate</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>200 HMMOS</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>UNKNOWN</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>177X</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July 5</i> , 19 <i>67</i> , to <i>Jan. 21</i> , 19 <i>68</i> , that (I) (we) lost the deceased alive on <i>Jan. 21</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Victor L. Ramos, M.D.</i> DEGREE 22d. PHYSICIAN'S NAME (Type) <i>VICTOR L. RAMOS</i> | | | | | | 22e. ADDRESS <i>Western Md. State Hospital Hagerstown, Maryland</i> | | 22c. DATE SIGNED <i>Jan. 21, 1968</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE <i>1-23-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>BARTONS VILLE</i> | | 23d. LOCATION (City or Town) (County) (State) <i>BARTONSVILLE Fred Md</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>C.E. Hicks</i> Frederick, Md | | | | | | 25a. REC'D BY REGISTRAR DATE <i>Jan. 24 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

01010

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

01010

RECEIVED

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

RECEIVED

TO THE HONORABLE THE ATTORNEY GENERAL
STATE OF NEW YORK
FROM THE HONORABLE THE ATTORNEY GENERAL
STATE OF NEW YORK
SUBJECT: [Illegible]

[Illegible text follows, appearing to be a list or set of instructions.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01686

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | | | |
|--|---|--|--|--|---|--|---|--|---|
| 1. DECEASED-NAME (Type or Print) | | | First Robert | Middle Lee | Last Bowman | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> 1/9 19 68 | | | 2b. HOUR 2A |
| 3. SEX MALE | 4. RACE WHITE | 5. DATE OF BIRTH FEBRUARY 14, 1944 | 6. AGE (In years last birthday) 23 YRS. | IF UNDER 1 YEAR MONTHS _____ DAYS _____ | | IF UNDER 24 HRS. HOURS _____ MIN. _____ | | 2c. DATE PRONOUNCED DEAD Month 1 Day 9 Year 1968 | 2d. HOUR 3A |
| 7a. BIRTHPLACE (State or foreign country) WASHINGTON | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON | | | | Md. |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 213 EAST FRANKLIN ST. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 213 EAST FRANKLIN STREET | |
| 14. FATHER'S NAME First CHARLES Middle H. Last BOWMAN | | | 15. MOTHER'S MAIDEN NAME First CARLITA Middle _____ Last DUNAHUGH | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | |
| 16b. SOCIAL SECURITY NO. 214-42-1202 | | | 17. INFORMANT MRS. CARLITA D. BOWMAN, | | | ADDRESS 213 E. FRANKLIN ST. HAGERSTOWN, MARYLAND | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of abdomen DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 955X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) 976X | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Alcoholism and depression | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____ | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE Howard N. Weeks, M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 1/10/68 | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 580 Northern Ave | | | |
| | | | ADDRESS (Street, city, town, or county) | | | Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 1/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. | | | |
| 24. FUNERAL DIRECTOR Charles M. Royer | | | ADDRESS HAGERSTOWN, MARYLAND. | | | 25a. REC'D BY REGISTRAR JAN 11 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Jones | |

0138

Robert Lee Johnson

DATE

TIME

DEPT

OFFICE

1968-1969

Annual Report of the

Department of the Interior

1968

U.S. DEPARTMENT OF THE INTERIOR

WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last GEORGE RAUTH BREY | | | | | 2a. DATE OF DEATH Month Day Year Jan 3 1968 | | | 2b. HOUR 12.30 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 7 1889 | | 6. AGE (In years last birthday) YRS. 78 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Brooklyn N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Manager Motor Co | | 12b. KIND OF BUSINESS OR INDUSTRY Auto. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER 2090 Wood Hill Dr. | |
| 14. FATHER'S NAME First Middle Last Henry Brey | | | 15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Rauth | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes | | 16b. SOCIAL SECURITY NO. W.W.#1 214-09-1490 | | 17. INFORMANT Address Mrs Lillian U. Brey 2090 Wood Hill Dr | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immed. 3 yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 20, 1966 , to Jan 3, 1968 , that (I) (we) last saw the deceased alive on Dec 15, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Clord A. Hoffman | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/4/68 | | | |
| 22d. PHYSICIAN NAME (Type) Lloyd A. Hoffman | | | | 22e. ADDRESS 214 N. Pot. St. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/7/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md. | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman | | | | ADDRESS Hagerstown Md | | 25a. REC'D BY REGISTRAR JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J... | |

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1. The first part of the report is a general statement of the work done during the year. It is a summary of the work done by the various departments of the institution, and is intended to give a general impression of the work done during the year.

2. The second part of the report is a detailed statement of the work done by each of the departments. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

3. The third part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

4. The fourth part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

5. The fifth part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

6. The sixth part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

7. The seventh part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

8. The eighth part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

9. The ninth part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

10. The tenth part of the report is a statement of the work done by the various departments of the institution. It is a summary of the work done by each of the departments, and is intended to give a detailed impression of the work done during the year.

01688

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01679

| | | | |
|--|----------------------------------|--|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN 1b 50 YRS. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | d. STREET ADDRESS 1032 LINCOLN ST. | |
| 3. NAME OF DECEASED (Type or print) First Middle Last GEORGE MAHLON BURKER | | 4. DATE OF DEATH Month Day Year JANUARY 11 1968 | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6/4/1889 |
| 9. AGE (In years lost birthday) 78 yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED JANITOR | | 10b. KIND OF BUSINESS OR INDUSTRY APT. HOUSE | |
| 11. BIRTHPLACE (County & State, or foreign country) VIRGINIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME THOMAS LEE BURKER | | 14. MOTHER'S MAIDEN NAME VIRGINIA BREEDEN | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 227-07-3945 | |
| 17. INFORMANT MR. JACOB BURCKER | | HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 1621 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Lung (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 163x Chronic Bronchitis (General) | | INTERVAL BETWEEN ONSET AND DEATH ? | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1968 to Jan 11, 1968 , that (I) (we) last saw the deceased alive on Jan 11, 1968 , and that death occurred at M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE J. H. Roachley | | 22b. DATE SIGNED Jan 17/68 | |
| 22c. PHYSICIAN'S NAME (Type) J. H. Roachley | | 22d. ADDRESS Hagerstown, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1/13/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. GARDENS HAGERSTOWN | | 23d. LOCATION (City or Town) (County) (State) MD. | |
| 24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR JAN 15 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| <div>01689</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>01680</div> | | | | | | | | | | | |
|---|--|--|---|---|---|--|---|--|---|--|---|
| 1. DECEASED-NAME (Type or print) CHARLES HARRY BURNETT | | | | | | 2a. DATE OF DEATH Month JANUARY Day 10 , Year 1968 | | | 2b. HOUR 4:35 ^A | | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MAY 19, 1895 | | | 6. AGE (In years last birthday) 72 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) PENNA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | |
| 10. CITY OR TOWN OF DEATH HANCOCK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 160 E. MAIN STREET | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) BALTIMORE & OHIO RAILROAD | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HANCOCK | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 160 E. MAIN STREET | | |
| 14. FATHER'S NAME First Middle Last FRANK BURNETT SR. | | | | 15. MOTHER'S MAIDEN NAME First Middle Last JOSEPHINE GRAHAM | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) YES | | | 16b. SOCIAL SECURITY NO. W.W.1 705/12/7103 | | 17. INFORMANT Address HANCOCK, MD. LILLIE E. BURNETT 160 E. MAIN ST. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150x CONGER ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) 150x | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from none , 19____, to none , 19____, that (I) (we) last saw the deceased alive on 12 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE FB Thomas III M.D. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/12/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) FB Thomas III M.D. | | | | | | 22e. ADDRESS HANCOCK, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 1/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY ALPINE E.U.B. CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) MORGAN CO., W.VA. | | | | |
| 24. FUNERAL DIRECTOR Howard J. Skone Hancock Md | | | | | | 25a. REC'D BY REGISTRAR JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... | | | |

01681

01680

| | | | | |
|-------------------|--------------------|--------------------|---------------------------|--------------------|
| CHARLES | HARRY | TURBETT | JANUARY | 10, 1908 |
| MALE | WHITE | MAY 10, 1902 | SS | |
| PENNA. | U.S.A. | X | WASHINGTON | |
| HANCOCK | 100 E. MAIN STREET | 100 E. MAIN STREET | BALTIMORE & OHIO RAILROAD | |
| MARYLAND | WASHINGTON | HANCOCK | X | 100 E. MAIN STREET |
| FRANK TURBETT SR. | JOSEPHINE GRAHAM | | | |
| YES | U.S.A. | 100 E. MAIN STREET | 100 E. MAIN STREET | |

[Faint, illegible handwritten notes and signatures are visible in this section.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

| | | | | | | | | | |
|--|--|--|---------|---|------|--|--|--|-------------------|
| 01690 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01681 | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR A M | |
| ELIZABETH | | | REBECCA | CALHOUN | | Jany 5 1968 | | 11 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | | White | | Jany 31 1899 | | 68 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Greencastle | | USA | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Wash. County Hospital | | Knitter | | Hosiery Co | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Hagerstown | | | | 43 E. Baltimore St | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First Middle Lost |
| Harry N. Reeder | | | | | | Susan Morganthal | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | Ave | |
| No | | 314-09-2963 | | Mrs Betty Millward | | 441 Stratford | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized peritonitis</u> 5400 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>5501</u> (b) <u>Ruptured appendicitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>2 weeks</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>Paralysis due to Cerebral Vascular Accident</u> <u>6 mos</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 12-28-67 | | Acute Appendicitis, ruptured | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 28</u> , 19 <u>67</u> , to <u>Jan. 5</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Jan. 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| John A. Moran M.D. | | 1-6-68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| John A. Moran, M.D. | | 215 W. Washington St., Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/9/68 | | Rest Haven Cemetery | | Hagerstown Wash Co Md | | | |
| 24. FUNERAL DIRECTOR | | Hagerstown | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Andrew K. Coffman | | Funeral Home Inc | | | | JAN 9 1968 | | Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

01691

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01682

| | | | | | | | | | | |
|---|--|---|---|---|--|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Grace Madeline Cartnail | | | 2a. DATE OF DEATH Month January Day 17 Year 1968 | | | 2b. HOUR 12:30AM | | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH 8/24/80 | | 6. AGE (In years last birthday) 87 YRS. | | IF UNDER 1 YEAR MONTHS OAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) U.S.A. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE Maryland | | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Libertytown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER MAIN ST. | |
| 14. FATHER'S NAME First Daniel Middle Rhodes Last Harris | | | 15. MOTHER'S MAIDEN NAME First Reba Middle Harris Last Harris | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (or unknown) | | | 16b. SOCIAL SECURITY NO. 214-03-5981 | | 17. INFORMANT Address Mrs. Thelma Tucker, Libertytown, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of bladder 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) 1810 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Sept. 18 , 19 67 , to Jan. 17 , 19 68 , that (I) (we) last saw the deceased alive on Jan. 17 , 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Dominic A. Garcia | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/17/68 | | |
| 22d. PHYSICIAN'S NAME (Type) D. A. Garcia, M.D. | | | | | | 22e. ADDRESS Western Maryland State Hospital Hagerstown, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE 1/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY WESLEY CEMETERY | | 23d. LOCATION (City or Town) (County) (State) LIBERTYTOWN MD | | | |
| 24. FUNERAL DIRECTOR W. A. Slaughter & Sons | | | ADDRESS LIBERTYTOWN | | 25a. REC'D BY REGISTRAR 146 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | DATE JAN 22 1968 | |

MEDICAL CERTIFICATION

00210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|---|---|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01692 | | | | | | | | | |
| 01683 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Jesse Clay Charles | | | | | | January 22 1968 | | 2:50P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | White | | August 7, 1889 | | 78 YRS. | | 5 15 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Big Springs, Md. | | U. S. A. | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Washington County Hospital | | Machinist | | Manufacturing | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Boonsboro | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 221 Potomac St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Milton Charles | | | Amanda F. Ebersole | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No. | | | 214-09-6017 | | Boonsboro, Md. Mrs. Edna M. Chalres, 221 Potomac St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Left Ren. flegria</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4380</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3. Days</u> <u>10 Days</u> <u>YEARS</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>334X</u> <u>Compensatory Renal failure</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>YES</u> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-10</u> , 19 <u>68</u> , to <u>1-22</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-22</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph Secondari</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1-23. 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI | | | | 22e. ADDRESS Boonsboro Md 21713 | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-25-68 | | Mountain View Cemetery | | Sharpsburg, Wash. Co. Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. | | | | 112 N. Main St. Boonsboro, Md. | | JAN 26 1968 | | <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
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 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|-----------------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Susan Izora Clark | | | | | | January 16, 1968 | | | 915A.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| female | | white | | 5-1-1879 | | | 88 YRS. | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West, Virginia | | USA | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Washington County Hosp. | | | Housewife | | Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Md. | | | Wash. | | Hagerstown | | | | 1612 Howell Road |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Adam Spring | | | | | | Rhoda Ziler | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| no | | | None | | | Mr. John W. Clark Oradell, N.J. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4339 IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 332x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from March, 1963, to Jan., 1968, that (I) (we) last saw the deceased alive on Jan. 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | 22d. ADDRESS | | | | |
| Howard N. Weeks | | 1/17/68 | | | 580 Northern Avenue Hagerstown, Maryland | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | 22f. LOCATION (City or Town) (County) (State) | | | | |
| Howard N. Weeks, M.D. | | | | | Berkley Springs W. Va. | | | | |
| 23a. BURIAL, CREMATION, or other disposal (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-19-68 | | Greenway Cemetery | | Berkley Springs W. Va. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Minnich Funeral Home Hagerstown, Md. | | | | | JAN 22 1968 | | James J. J... | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|---------|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| ANDREW KENDALL COFFMAN | | | | | | Jan. 13 1968 | | | 10: p.m. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | White | | August 20, 1870 | | 97 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Bakersville? Md | | U.S.A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | 40 E. Antietam St | | | Funeral Director | | Owner | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Washington | | | Hagerstown | | 40 East Antietam St | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Peter | | | | | Coffman | Elizabeth | | | Kendall |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| No | | | 219-07-5417 | | | Mrs. Gladys B. Coffman, 40 E. Antietam | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Colon, sigmoid</u> 1533 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1533 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-5, 1941, to 1-13, 1968, that (I) (we) last saw the deceased alive on 1-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE John H. Hombaker, M.D. | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-15-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS 154 West Washington St., Hagerstown, Md. 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan. 17, 1968 | | Rose Hill Cemetery | | Hagerstown, Wash. | | Md | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| A.K. Coffman Funeral Home, Hagerstown, Md | | | | | | JAN 17 1968 | | Charles Judge | |

1882

OFFICE OF THE SECRETARY OF THE ARMY

REPORT OF THE SECRETARY OF THE ARMY

FOR THE YEAR 1882

1882

REPORT OF THE SECRETARY OF THE ARMY

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FOR THE YEAR 1882

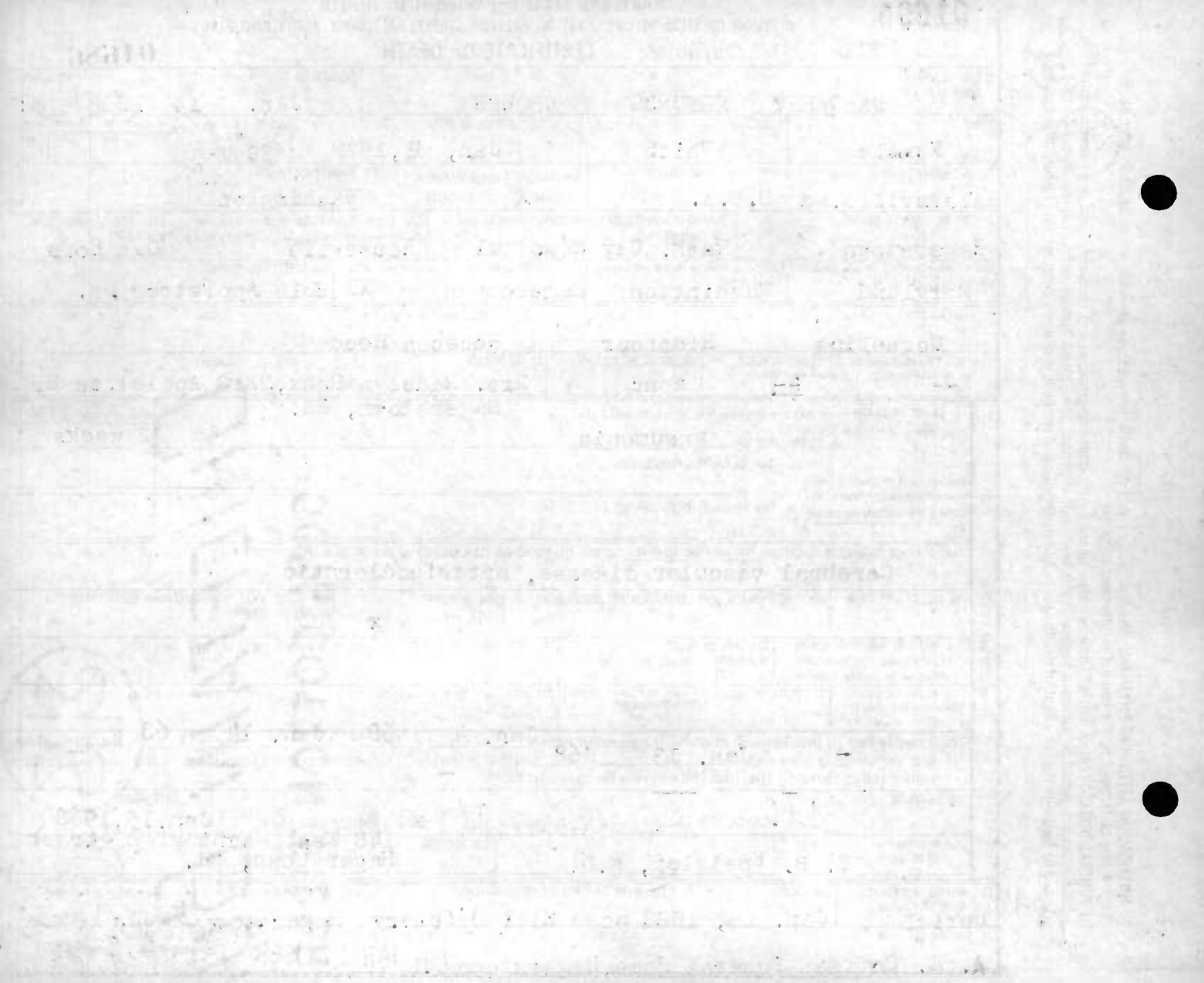
REPORT OF THE SECRETARY OF THE ARMY

FOR THE YEAR 1882

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---------|--|------------------|------------------------------------|---|---------------------------------|--|---|--|------------------|
| Item 6 Film G397 1/24/68 kk | | | | | CERTIFICATE OF DEATH | | | | | 01686 | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| MARGARET EDMUNDS CROMER | | | | | | Jan. 14 1968 | | | 6 a.m. | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| Female | | White | | Jan. 31, 1879 | | | 89 88 YRS. | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Bakersville, Md | | | U.S.A. | | | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Wash. Cty Hospital | | | Housewife | | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | | Hagerstown | | | | 2312 Appletree Dr. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Cornelius Ridenour | | | | | | Rebecca Reed | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| Yes, --, or (unknown) | | | None | | | Mrs. Madelyn Ruck | | | 2312 Appletree Dr | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | 2 weeks | |
| IMMEDIATE CAUSE (a) <u>Pneumonia</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) _____ | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) _____ | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| Cerebral vascular disease, arteriosclerotic | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 4, 1968, to Jan. 14, 1968, that (I) (we) last saw the deceased alive on Jan. 13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>B. B. Kneisley</u> | | | | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | |
| | | | | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | |
| | | | | | | 22e. ADDRESS | | | 22f. REGISTRAR'S SIGNATURE | | |
| | | | | | | 148 West Washington Street | | | Jan. 15, 1968 | | |
| | | | | | | Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Jan. 16, 1968 | | Rose Hill Cemetery | | | Hagerstown Wash. Md | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| A. K. Coffman Funeral Home, Hagerstown | | | | | | DATE | | | JAN 17 1968 | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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| 01696 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01687 | | | | | | | | | | | | | | | | | | | |
|--|--|----------------------|--|---|--|--|--|--|--|---|--|---|--|--|--|--|--|--|--|---|--|-------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) First Middle Last WILLIAM BENJAMIN CURRY | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 7:30 P. M. | | | | | | | | | | 2b. DATE PRONOUNCED DEAD <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Jan. 13, 1968 | | | | | | | | | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH March 28, 1919 | | 6. AGE (In years lost birthday) 48 YRS. | | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | | 2c. DATE PRONOUNCED DEAD <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year Jan. 13, 1968 | | | | | | | | | | 2d. HOUR M | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Washington | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Cty Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cook | | | | 12b. KIND OF BUSINESS OR INDUSTRY W. Md State Hospital | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | | | 13b. COUNTY Washington | | | | 13c. CITY OR TOWN Hagerstown | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 429 N. Locust St | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last John R. Curry | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Frances Sealock | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes | | | | | | | | | | 16b. SOCIAL SECURITY NO. W.W. #2 219-05-3402 | | | | | | | | | | 17. INFORMANT ADDRESS Mrs. Elsie B. Kump, 11 Berner Ave Hagerstown, Md. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct, Old DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 (b) Coronary Atherosclerosis, Severe DUE TO, OR AS A CONSEQUENCE OF Cardiac Hypertrophy (c) Ventricular Arrhythmia | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several months Few minutes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. | | | | | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | 22b. DATE SIGNED Jan. 15, 1968 | | | | | | | | | | | | | | | | | | | |
| EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | | | | | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 1/16/68 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR A.K. Coffman Funeral Home, Hagerstown, Md. | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR JAN 17 1968 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | | | | | | | |

01798

01827

Jan 22 1958

215 S. Washington St., Lexington, Ky.

Dr. J. H. Dille, Jr.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------|---|--|--|--|--------------------------------|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month / Day / Year | | | 2b. HOUR |
| MARY | | | HELEN | DANZER | | 1 / 20 / 68 | | | 11 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| FEMALE | | WHITE | | MAY 5, 1882 | | 85 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| MARYLAND | | U.S.A. | | | | WASHINGTON | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| WILLIAMSPORT | | WILLIAMSPORT SANITARIUM | | HOMEMAKER | | OWN HOME | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | WASHINGTON | | HAGERSTOWN | | | | 832 OAK HILL AVENUE | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last |
| JOHN | | W. | COST | | SARAH | | JANE | BOMBERGER | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | 832 OAK HILL AVENUE, HAGERSTOWN, MARYLAND. | | | |
| NO | | NONE | | MR. FRANK E. DANZER | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Approximate interval between onset and death: <u>6 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>4-5 years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) <u>(did not)</u> attended the deceased from <u>7/6</u> , 19 <u>65</u> , to <u>Jan 20</u> , 19 <u>68</u> , that (I) <u>(was)</u> lost saw the deceased alive on <u>1/20/68</u> , 19 <u>68</u> , and that in (my) <u>(own)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(may)</u> <u>(did)</u> view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>George Jennings</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/22/68 | | |
| 22d. PHYSICIAN'S NAME (Type) GEORGE JENNINGS, M.D. | | | | | 22e. ADDRESS 318 N. POTOMAC ST. HAGERSTOWN, MARYLAND. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 1/23/68 | | ROSE HILL CEMETERY | | HAGERSTOWN, WASH. CO. MD. | | | |
| 24. FUNERAL DIRECTOR <u>Harold M. Kasper</u> | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE <u>Francis Judge</u> | | |
| HAGERSTOWN, MARYLAND. | | | | | JAN 24 1968 | | | | |

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UNITED STATES OF AMERICA

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RECEIVED
JULY 1951

OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D. C.

TO THE HONORABLE THE SENATE
WASHINGTON, D. C.

FROM THE ATTORNEY GENERAL
JULY 1951

SUBJECT: [Illegible]

[Illegible text]

[Illegible text]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|----------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Linda | | | Middle Kay | | | Last Daymude | | | 2a. DATE OF DEATH Month January Day 18, Year 1968 | | | 2b. HOUR 4:55A | | |
| 3. SEX female | | | 4. RACE white | | | 5. DATE OF BIRTH 6-30-47 | | | 6. AGE (In years last birthday) 20 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | | IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Pennsylvania | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Phototone | | | 12b. KIND OF BUSINESS OR INDUSTRY Card Mfg. | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 1424 Jefferson Blvd. | | | | | |
| 14. FATHER'S NAME First Crawford A. Middle Wishard Last | | | 15. MOTHER'S MAIDEN NAME First Lillian Middle Woodring Last | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 216-48-7189 | | | 17. INFORMANT Address Mr. Charles E. Daymude Hagerstown, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrhythmia 7463 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2542 (b) Interventricular septal defect DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs 20 yrs. | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d) Pregnancy delivered 27 wks. placenta praevia | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/17/68 , 19 68 , to 18 Jan , 19 68 , that (I) (we) lost the deceased alive on 18 Jan , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Harold H. Gist M.D. | | | DEGREE M.D. | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 19 Jan 1968 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 1-21-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Greenhill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Waynesboro Pennsylvania | | | | | | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | | ADDRESS | | | 25a. REC'D BY REGISTRAR DATE JAN 22 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | | |

01553

STATE OF TEXAS

01553

County of _____ State of Texas
Know all men by these presents, that _____ of the County of _____ State of Texas, for and in consideration of the sum of _____ Dollars, to _____ of them in hand paid by _____ the receipt of which is hereby acknowledged, have granted, sold and conveyed, and by these presents do grant, sell and convey unto the said _____ of the County of _____ State of Texas, all that certain _____ of _____ Acres, more or less, situated in _____ County, State of Texas, to have and to hold unto the said _____ heirs, assigns and assigns forever.
Witness my hand and seal of office this _____ day of _____ 19____.

County Clerk

Notary Public

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01699

CERTIFICATE OF DEATH

01690

| | | | | | | | | | | | |
|--|--|--|---|---|------|---|--|---|---|--|----------------------|
| 1. DECEASED-NAME (Type or print) Doris | | | First | Middle | Lost | 2a. DATE OF DEATH Month 1 Day 20 Year 68 | | | 2b. HOUR 4:20 PM | | |
| 3. SEX female | | 4. RACE white | | 5. DATE OF BIRTH 7-10-21 | | | 6. AGE (In years last birthday) 46 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Nurse | | | 12b. KIND OF BUSINESS OR INDUSTRY County Hosp. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 416 Virginia Ave. | |
| 14. FATHER'S NAME Edward | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME Ruth | | | First | Middle | Last Trone |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 217-30-6068 | | | 17. INFORMANT Address Mr. John Doarnberger Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatic Coma 571.8 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 5810 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 67 to 1/20 , 19 68 , that (I) (we) last saw the deceased alive on 1/20 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE J. D. Wilson | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/22/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) J. D. WILSON | | | | | | 22e. ADDRESS HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 1-22-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE JAN 25 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01691

| | | | | | | | | | | | |
|---|---------|---|---|---|--|---|--|---|---|----------------------------|---|
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF ESTI- DEATH MATED | | | | 2b. HOUR | |
| Charles Samuel Eckstine | | | | | | Month Day Year | | | | 19 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | July 28, 1886 | 81 YRS. | | | | | Month Day Year | | 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| Washington Co. Md. | | | USA | | | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | 139 Summit Ave. | | | Mail Carrier | | | U.S. Postoffice | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Md. | | | Washington | | | Hagerstown | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | | | |
| First Middle Last | | | First Middle Last | | | 139 Summit Ave. | | | | | |
| Jacob Eckstine | | | Eliza Virginia Startzman | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | 215-36-7078 | | | Mr. Kenneth E. Eckstine | | | 104 Williams Circle | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pending</u> Cardiac hypertrophy | | | | | | | | | | | Recent |
| DUE TO, OR AS A CONSEQUENCE OF Ischemic fibrosis of myocardium | | | | | | | | | | | |
| (b) <u>Pulmonary congestion & edema</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF Passive congestion of viscera | | | | | | | | | | | |
| (c) <u>Pulmonary emphysema</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 527.1 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 1-5-68 | | | |
| Dr. E. W. Ditto, Jr. | | | | 225 W. Washington St., Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 11/5/68 | | Rest Haven Cemetery | | | | Hagerstown Washington Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Wm. C. Hunt | | | | Hagerstown, Md. | | | | DATE JAN 9 1968 | | Charles Judge | |

| | | | | |
|--|--------------------|----------------------------------|-------------------------|------------------------|
| 1. Name of Deceased | 2. Sex | 3. Age | 4. Date of Death | 5. Place of Death |
| 6. Cause of Death | 7. Manner of Death | 8. Signature of Medical Examiner | 9. Signature of Coroner | 10. Signature of Juror |
| <p>11. History of Illness</p> <p>12. Post-mortem Examination</p> <p>13. Toxicology</p> <p>14. Other Findings</p> | | | | |

FILED

1968

JAN 9 1968

W.C. Carter

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|---|------------------------|---|---|---|---|--|--|--|
| 01701 | | 01692 | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First <i>John</i> | Middle <i>Lewis</i> | Last <i>Eichelberger</i> | 2a. DATE OF DEATH Month <i>9</i> Day <i>1968</i> Year <i>1968</i> | | 2b. HOUR <i>6:45 P.M.</i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>August 9, 1881</i> | | 6. AGE (In years last birthday) <i>86</i> YRS. | | IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Wash. Co. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Washington</i> | | Md. | | |
| 10. CITY OR TOWN OF DEATH <i>Hagerstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Maintenance</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Aircraft</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Washington</i> | | 13c. CITY OR TOWN <i>Hagerstown</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>803 Washington Ave.</i> | | |
| 14. FATHER'S NAME First <i>Lewis</i> | | Middle <i>Eichelberger</i> | | Last <i>Catherine</i> | | 15. MOTHER'S MAIDEN NAME First <i>Catherine</i> | | Middle <i>McCalister</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i> | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. <i>214-09-3801</i> | | 17. INFORMANT <i>Mrs. Hazel Demmitt</i> | | Address <i>12 N. Main St. Boonsboro, Md.</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic vascular disease</i> <i>440.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Haemorrhage of gastric ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i> <i>4 days</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4500</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 7, 1968</i> , to <i>Jan 9, 1968</i> , that (I) (we) last saw the deceased alive on <i>Jan 9, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>G. W. LeVan M.D.</i> | | | | | DEGREE <i>M.D.</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>Jan 11, 1968</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>G. W. LeVan M.D.</i> | | | | | 22e. ADDRESS <i>Boonsboro, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/12/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Hagerstown Washington Md.</i> | | | | |
| 24. FUNERAL DIRECTOR <i>Wm. G. Horst</i> | | | | | ADDRESS <i>Rest Haven Funeral Chapel Hagerstown, Md.</i> | | 25a. REC'D BY REGISTRAR DATE <i>JAN 15 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01702 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01693 | | | | |
|---|--|--|--|---|---|---|--------------------------------------|--|--------------------------------|--|--------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | | 2b. HOUR A HOUR | |
| MARY | | | | RUTH | ELGIN | | Jany 3 1968 | | | | 6.30 ^{PM} | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| Female | | White | | Feby 3 1890 | | | 77 | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| Maryland | | USA | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Hagerstown | | Wash County Hospital | | | Housewife | | | Own Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | |
| Maryland | | Washington | | Hagerstown | | | | 406 W. Howard St | | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| James B. Newcomer | | | | Lucretia Gower | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address | | | | | | | | |
| No | | None | | W. Lee Elgin 406 W. Howard St Hagerstown Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma toxi</u> <u>1538</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>1538</u> (b) <u>Adenocarcinoma large bowel</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>?</u> <u>?</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension -</u> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>19 Dec</u> , 19 <u>67</u> , to <u>Jan 3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2 Jan</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Elden D Hoachlen</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED <u>11/5/68</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>Elden D Hoachlen</u> | | | | | | 22e. ADDRESS <u>Hagerstown Md</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | 1/6/68 | | Rest Haven Cemetery | | Hagerstown Wash Co Md. | | | | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc | | | | | | 25a. REC'D BY REGISTRAR DATE <u>JAN 8 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | | | | |

TO THE SECRETARY OF THE INTERIOR

FROM THE SECRETARY OF THE INTERIOR

RE: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|---|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Margaret Carson Elliot | | | 2a. DATE OF DEATH Month Jan Day 24 Year 1968 | | | 2b. HOUR 3:45M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH March 9, 1891 | | 6. AGE (In years last birthday) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Penna. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY None | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1745 Preston Road | |
| 14. FATHER'S NAME First James Middle S. Last Carson | | | 15. MOTHER'S MAIDEN NAME First Isabelle Middle F. Last Carr | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> no, <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> (If yes give war or dates of service) No | | 16b. SOCIAL SECURITY NO. 218-34-3682 | | 17. INFORMANT Francis T. Elliot, Jr. | | Address New Market, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary thrombosis 4109 DUE TO, OR AS A CONSEQUENCE OF Arteriosclereosis of the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min. unknown | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Leukemia, Hepatitis, pulmonary emphysema, bronchiectasis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-25-67 , 19__, to 1-24-68 , 19__, that (I) (we) last saw the deceased alive on Jan 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE E.R. Lardizabal MD | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-25-1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) E.R. Lardizabal MD | | 22e. ADDRESS 300 N. Potmac, Hagerstown, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan. 27, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery | | 23d. LOCATION (City or Town) (County) (State) Taneytown Carroll Maryland | | | |
| 24. FUNERAL DIRECTOR John M. Skiles | | ADDRESS C.O. Fuss & Son, John M. Skiles, Taneytown, Md. | | 25a. REC'D BY REGISTRAR JAN 29 1968 | | 25b. REGISTRAR'S SIGNATURE James Judge | | | |

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CERTIFICATE OF DEATH

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|--|--|--|--|---|--|---|---|---|--|---|--|
| 1. DECEASED-NAME (Type or print) Sidney F. Ellis | | | 2a. DATE OF DEATH Month January Day 9 Year 1968 | | | 2b. HOUR 6:30A M | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH August 26, 1876 | | 6. AGE (In years last birthday) 91 YRS. | | IF UNDER 1 YEAR MONTHS 4 DAYS 13 | | IF UNDER 24 HRS. HOURS 4 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Lewisburg, N.C. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Boonsboro | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fahrney-Keedy Mem. Home | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cabinet Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 327 Mc Dowell Ave. | | |
| 14. FATHER'S NAME First Sidney Middle Ellis Last | | | 15. MOTHER'S MAIDEN NAME First Mary Middle Burrows Last | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 214-09-3041 | | 17. INFORMANT Address Fahrney- Keedy Home Records Boonsboro, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accelerated Heart Disease 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 4200 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 10 , 19 67 , to Jan 9 , 19 68 , that (I) (we) last saw the deceased alive on Jan 8 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE G. Whelan | | DEGREE G. Whelan | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 9, 1968 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) G. Whelan | | 22e. ADDRESS Boonsboro, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1- 12- 68 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | 25a. REC'D BY REGISTRAR DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01705 | | | | | | | | | |
| 01696 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Helen Wilhelmina Banzhoff Eshelman | | | | 2a. DATE OF DEATH Month 12 Year 1968 | | 2b. HOUR 6:30A M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH Dec. 3, 1900 | | 6. AGE (In years last birthday) 67 YRS. | | IF UNDER 1 YEAR MONTHS 1 DAYS 9 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington | | Md. | |
| 10. CITY OR TOWN OF DEATH Boonsboro | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Reeder Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Boonsboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER Rfd. 1 | |
| 14. FATHER'S NAME First Middle Last James F. Banzhoff | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Ivie Myrtle Myers | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | 16b. SOCIAL SECURITY NO. Unknown | | 17. INFORMANT Address Washington Co. Welfare Dept. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs 10 yrs | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 260x | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 5, 1967 , to Jan 12, 1968 , that (I) (we) last saw the deceased alive on Jan 11, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE G. W. Leland | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 13, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) G. W. Leland | | | | 22e. ADDRESS Boonsboro Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-15-68 | | 23c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery | | 23d. LOCATION (City or Town) (County) (State) Williamsport Wash. Co. Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | 25a. REC'D BY REGISTRAR JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE Charles George | | | |

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1. *Journal of the American Medical Association*, 1997; 278: 1021-1025.

• *Journal of the American Medical Association*

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CERTIFICATE OF DEATH

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|---|--|--|---|---|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Cumberland Thomas Eubanks | | | 2a. DATE OF DEATH Month Jan Day 5 Year 1968 | | | 2b. HOUR M | | | |
| 3. SEX Male | | 4. RACE Colored | | 5. DATE OF BIRTH Aug 8 1900 | | 6. AGE (In years lost birthday) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Pedlar Mills Va. USA. | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 647 Forrest Dr. | |
| 14. FATHER'S NAME First William Middle (NMN) Last Eubanks | | | 15. MOTHER'S MAIDEN NAME First Lottie Middle (NMN) Last Roach | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | | 16b. SOCIAL SECURITY NO. 220-26-0021 | | 17. INFORMANT Address Mrs Cornelia Eubanks 647 Forrest Dr. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gen. Carcinomatosis 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CA of Lung DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 5 yrs. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 163X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1-65 , 19 65 , to 1-5 , 19 68 , that (I) (we) last saw the deceased alive on 1-4 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Robert P. Conrad | | DEGREE MD. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-5-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert P. Conrad | | 22e. ADDRESS 137 W. Washington Hagerstown Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan 9 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash. Md. | | | |
| 24. FUNERAL DIRECTOR John R Watson of Hagerstown Md. | | | | 25a. REC'D BY REGISTRAR 1 JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 18. PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|---------|------------------------------|--|--|-----------------------------------|---|---|----------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Charles WILLIAM Faith | | | | | | Month Day Year | | | 2:05 A. M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| M | W | 12.9.17 | 50 YRS. | MONTHS | DAYS | HOURS | MIN | Month Day Year | 19 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| WHITAKER PA. | | U.S.A. | | | | WASHINGTON MD. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| HAGERSTOWN MD | | | WASHINGTON COUNTY OPERATOR | | | P.&E | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| MD | | | WASHINGTON WMSPT. | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 36 W. POTOMAC ST. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| CHARLES A FAITH | | | CLARA LININGER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| Y | | | 41 | | WMSPT. MD. | | | | |
| | | | 203.10.2766 | | DOROTHY R FAITH 36 W. POTOMAC ST. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>With Probable Atheromatous Occlusion Of Rt. Coronary Artery</u> | | | | | | | | | Instant |
| (b) <u>Healed Myocardial Infarction, Extensive Comp-rising Anterior And Posterior Septum And Extending To The Left Ventricular Wall</u> | | | | | | | | | Recent |
| (c) <u></u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| <u>4201 Acute Pulmonary Edema; Pleural Effusion, Bilateral.</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| <u>E. W. Ditto, Jr.</u> | | | | | | 1-22-68 | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | | | | |
| Dr. E. W. Ditto, Jr. | | | 215 W. Washington St., Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 1.23.68 | | GREEN LAWN | | WMSPT. WASHINGTON MD. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>Howard J. Stene</u> | | | <u>Hagerstown, Md.</u> | | | DATE | | <u>Jan 24 1968</u> | |

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Jan. 21, 1951

WILLIAM

James

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--------------------------|--|---|---|--|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01708 | | | | | | | | | |
| 01699 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| John Howard Ferguson | | | | | | January 27, 1968 | | | 7:20A |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| male | | white | | Oct. 14, 1911 | | 56 YRS. | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| Maryland | | U.S.A. | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | 539 Salem Ave. | | | car inspector | | | railroad | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Wash. | | Hagerstown | | | | 539 Salem Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Robert Ferguson | | | Leah Getchie | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| no | | | | | Mrs. Violet Ferguson, Hagerstown, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4201</u> (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | Dec 19 67, to 27 Jan 19 68, that (I) (we) last saw the deceased alive on 26 Jan 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from | | | 22b. SIGNATURE | | | | | | |
| | | | J. Wilson | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| | | | | | | | 1/29/68 | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-30--68 | | Salem Reformed Church | | Hagerstown, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home, Hagerstown, Md. | | | | JAN 31 1968 | | Charles Judge | | | |

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05-01-2004

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• *Chlorophyll*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--------------------------------|---|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED NAME (Type or print) Wallace William Fredericks | | | | | | 2a. DATE OF DEATH 1 Month 29 Day 68 Year | | | 2b. HOUR 10:10 P.M. | | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH 11/1/1898 | | | 6. AGE (In years last birthday) 69 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Truck driver | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 112 Ice Street | | |
| 14. FATHER'S NAME First Middle Lost Samuel NMN Fredericks | | | | 15. MOTHER'S MAIDEN NAME First Middle Lost Lee Ellen Magruder Stein | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 233-05-8593 | | 17. INFORMANT Address Fred. Md Idella A. Fredericks 112 Ice Street | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 185X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of prostate | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 days unknown 4 years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 177X | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 12/18/67 , 19 68 , to 1/29 , 19 68 , that (I) (true) lost the deceased alive on Jan. 29 , 19 68 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE Victor L. Ramos, M.D. | | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/30/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D. | | | | | | 22e. ADDRESS Western Md. State Hospital, Hagerstown | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 2-3-68 | | 23c. NAME OF CEMETERY OR CREMATORY Ebenezer Church | | 23d. LOCATION (City or Town) (County) (State) Centerville Fred. Md | | | | | | |
| 24. FUNERAL DIRECTOR C.E. Hicks, 111 Frederick, Maryland | | | | | | 25a. REC'D BY REGISTRAR JAN 31 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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OFFICE OF DEATH

DATE: 10-10-1961

NAME: [illegible]

ADDRESS: [illegible]

CITY: [illegible]

STATE: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

CAUSE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

DATE OF CREMATION: [illegible]

PLACE OF CREMATION: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

DATE OF INTERMENT: [illegible]

PLACE OF INTERMENT: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 20. DATE OF DEATH | | | 2b. HOUR |
| CHARLES VALENTINE GENTHNER | | | | | | Month Day Year 1 31 68 | | | AM 10.55 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| M | | WHITE | | MARCH 28 1893 | | | 74 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | |
| NEWARK N.Y. | | U.S.A. | | | | | WASHINGTON MARYLAND Md. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| HAGERSTOWN | | | WASHINGTON COUNTY HOSP. | | | LABOR | | | LABOR |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| MARYLAND | | | WASHINGTON | | | HANCOCK | | RURAL 1 | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| GEORGE V GENTHNER | | | CORA PARKER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| | | | 079 01 5994 | | | MARTHA GENTHNER RURAL 1 HANCOCK MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> | | | | | | | | | 4 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive Cardio-vascular Disease</u> | | | | | | | | | ? |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 443X <u>Pulmonary emphysema, Adenocarcinoma</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-28</u> , 19 <u>68</u> , to <u>1-31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-31</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>John H. Kehne M.D.</u> | | | | | | 22c. DATE SIGNED <u>2-1-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>JOHN H. KEHNE</u> | | | | | | 22e. ADDRESS <u>1229 RAVENWOOD Hts Hagerstown, Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| BURIAL | | 2.2.68 | | CATALPA METHODIST | | RURAL HANCOCK WASHINGTON | | MD | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>Howard J. Moore Hagerstown Md</u> | | | | DATE <u>7 1968</u> | | <u>Charles Judge</u> | | | |

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CONFIDENTIAL

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HOUGH, JOHN YOUNG, JR. TEX 11347

NOTES: NOTED 147.49

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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John A. White

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|--|--|------------------------------------|--|---|--|--|---|---|-------------------------------|------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | | | |
| Samuel Edward Giffin | | | | | | January 1, 1968 | | | 4:30PM | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | |
| Male | | White | | December 8, 1884 | | | 83 YRS. | | 0 23 | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | | |
| Dargan, Md. | | | U, S. A. | | | | | | Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Hagerstown | | | Washington Co. Hospital | | | Blacksmith | | | Stone Co. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | | Harpers Ferry | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | Rfd. 1, Dargan | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | |
| Emanuel Giffin | | | Sarah Jane Johnson | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | W. Va. | | | | |
| No. | | | | | | Mr. Carlos B. Giffin, Rfd. 1, Harpers Ferry | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>486x</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>493x</u> <u>Chronic renal disease</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 12/29/67 | | Pneumonia | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>1/1/68</u> , that (I) (we) lost saw the deceased alive on <u>1/1/68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>John R. Marsh</u> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <u>3 Jan 1968</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) John R. Marsh, M. D. | | | | | | 22e. ADDRESS 247 N. Potomac St., Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | 1-4-68 | | Samples Manor Cemetery | | | Samples Manor Wash. Co., Md. | | | | | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | 25a. REC'D BY REGISTRAR JAN 5 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>John H. Bast</u> | | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 017023 | | | | | |
|--|--|-------------------------|--|------------------------------------|--|---|--|--|---|---|--|---|--|----------------------|--|
| 1. DECEASED-NAME (Type or Print) | | | First William | | | Middle Jasper | | | Last Gilbert | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 1-3 19 68 | | 2b. HOUR M | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH 1-10-06 | | 6. AGE (In years last birthday) 61 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 0 | | IF UNDER 24 HRS HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD Month 1 Day 3 Year 19 | | 2d. HOUR M | |
| 7a. BIRTHPLACE (State or foreign country) Buena Vista, Va | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 832 Oak Hill Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Clerk | | | 12b. KIND OF BUSINESS OR INDUSTRY Liquor Store | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Wash. | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 218 Mealey Pkwy | | | | |
| 14. FATHER'S NAME First William Middle B. Last Gilbert | | | 15. MOTHER'S MAIDEN NAME First Sudie Middle Belle Last Snyder | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Mrs. Ruby Gilbert Hagerstown, Md. | | | ADDRESS | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending. Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF Abrasion & Laceration of Scalp & Nose (b) Hemorrhage, Minimal, Subcutaneous & Paraspinal, Cervical Region DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9000 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Suddenly | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Atherosclerosis and Arteriolarsclerosis Cardiac Hypertrophy | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. 6 P.M. 1-3 19 68 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell down cellar steps | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) 823 Oak Hill Avenue | | | 21f. LOCATION Street or R.F.D. No. Hagerstown City or Town Washington County Md State | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. | | | M.D. | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED 1-3-68 | | | | | | |
| EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 22c. WASHINGTON ST., HAGERSTOWN, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 1-6-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | | | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR JAN 9 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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01303

WILLIAM W. WILSON, JR.

WILLIAM W. WILSON, JR.

WILLIAM W. WILSON, JR.

WILLIAM W. WILSON, JR.

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WILLIAM W. WILSON, JR.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, #1 and #2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| | | | | | | | |
|--|--|--|--|---|--|---|--|
| 01713 | | MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01704 | |
| 1. DECEASED-NAME (Type or print) Louise Virginia Green | | | 2a. DATE OF DEATH Month January Day 26 , 1968 | | | 2b. HOUR 7:30P M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH July 24, 1920 | | 6. AGE (In years lost birthday) 47 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Benevola, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | |
| 10. CITY OR TOWN OF DEATH Boonsboro | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rfd. 2 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Boonsboro | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER Rfd. 2, San Mar | | 14. FATHER'S NAME First Carlton Middle Minnick Last | | 15. MOTHER'S MAIDEN NAME First Lydia Middle Bryan Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 215-14-2846 | | 17. INFORMANT Address Mr. Russell L. Green, Rfd. 2, Boonsboro, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 1538 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 1538 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1967 , to Jan 18, 1968 , that (I) (we) last saw the deceased alive on Jan 17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE G. W. LeVan | | DEGREE G. W. LeVan | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 20, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) G. W. LeVan | | 22e. ADDRESS Boonsboro, Md. | | | | | |
| 23a. BURIAL, CREMATION, etc. (Specify) Burial | | 23b. DATE 1-21-68 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cemetery | | 23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Md. | |
| 24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | 25a. REC'D BY REGISTRAR JAN 23 1968 | | 25b. REGISTRAR'S SIGNATURE James Judge | |

01313

RECEIVED BY THE U.S. DEPT. OF JUSTICE

STATE OF NEW YORK

01313

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|---|--|---|---|--|--|--|-------------------------|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Edward Livingston Grimm | | | | | | 2a. DATE OF DEATH Month January Day 8 Year 1968 | | | 2b. HOUR 11:30 A | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH January 11, 1902 | | | 6. AGE (In years lost birthday) 65 YRS. | | | IF UNDER 1 YEAR MONTHS 11 DAYS 27 | | |
| 7a. BIRTHPLACE (State or foreign country) Weaverton, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington | | | Md. | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1218 Virginia Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Cabinet Maker | | | 12b. KIND OF BUSINESS OR INDUSTRY Lumber Co. | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1218 Virginia Ave. | | |
| 14. FATHER'S NAME First Samuel J. Middle Grim Last Grim | | | | 15. MOTHER'S MAIDEN NAME First Alice C. Middle Jennings Last Jennings | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No. (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO. 220-09-9476 | | 17. INFORMANT Hagerstown, Md. Mrs. Grace B. Grimm, 1218 Virginia Ave. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) sudden cardiac arrest - ? ventricular fibrillation DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic heart disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 410.9 years + one month 4201 years | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-26 , 19 60 , to death , 19 68 , that (I) (we) lost saw the deceased alive on 3 Jan 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE John C. Stauffer | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | | | |
| 22d. PHYSICIAN'S NAME (Type) John C. Stauffer M. D. | | | | | | 22e. ADDRESS 145 S. Prospect St. Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition | | 23b. DATE 1- 11- 68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Maryland | | | | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | 25a. REG'D BY REGISTRAR JAN 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | |

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Alameda Division Office

File Date January 11, 1901 11 24

Received By U. S. A. 11 24

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> 01715 CERTIFICATE OF DEATH 01706 </div> | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| First Elmer Middle Theodore Last Gross | | | | | | Month January Day 3 Year 1968 | | 7:30PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | January 16, 1895 | | 72 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Antietam, Md. | | U. S. A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Rural Boonsboro | | | Rfd. 2 | | | Farmer | | Farming | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Maryland | | | Washington | | | Boonsboro | | Rfd. 2 | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | |
| John Gross | | | | Mary Drenner | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| Yes | | | W. W. One 215-26-1937 | | | Mrs. John Slifer, Boonsboro Rfd. 2, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> | | | | | | | | | Instantly |
| 4109 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 28</u> , 1968, to <u>Jan 28</u> , 1968, that (I) (we) lost the deceased on <u>Jan 28</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>G. W. Heelan</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>Jan 5, 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>G. W. Heelan</u> | | | | 22e. ADDRESS <u>Boonsboro, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-6-68 | | Boonsboro Cemetery | | Boonsboro, Maryland | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | DATE JAN 9 1968 | | <u>Charles Judge</u> | | | |

61510

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|---|---|---|---|---|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| First Middle Last MELVA KATHERINE GROVE | | | | | Month Day Year JANUARY 10, 1968 | | | A M 11:35 | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MAY 7, 1896 | | 6. AGE (In years last birthday) 71 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON COUNTY HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 927 GUILFORD AVENUE | |
| 14. FATHER'S NAME First Middle Last ALVERY G. HOFFMAN | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last EFFIE BELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO | | | 16b. SOCIAL SECURITY NO. 214-09-8151-B | | 17. INFORMANT Address EMORY S. GROVE 927 GUILFORD AVE. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary infarct</u> <u>4129</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4200</u> (b) <u>Arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonitis, or infarct rt lower lobe (PO Pharyngitis)</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. _____ 19____ | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>10-27, 1950</u> , to <u>death</u> , that (I) (we) last saw the deceased alive on <u>1-10-</u> 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert F. Keadle</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-11-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D. | | | | | 22e. ADDRESS 580 N. rthern Ave., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 1/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH., MD. | | | |
| 24. FUNERAL DIRECTOR <u>Harcourt & Kline</u> | | | | | ADDRESS <u>Harcourt & Kline</u> | | 25a. REC'D BY REGISTRAR DATE JAN 16 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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|---|--|--|--------------------------|---|---|--|--|--------------------------------|
| 01717 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01708 | | |
| CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR |
| Dora | | | Neilson | Hammaker | | January 16, 1968 | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Female | | White | | June 16, 1896 | | 71 YRS. | | IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. |
| Shepherdstown, W. Va. | | USA | | | | Washington | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | Washington County Hospital | | Housekeeper | | Own home | | |
| 13a. USUAL RESIDENCE (Where deceased admissible) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | County Wash | | Hagerstown | | | | 860 1/2 Virginia Ave. |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| Frank | | | Lloyd | Billmyer | | Hibernia Lee Snyder | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | |
| No | | | 213-48-0741 | | Marguerite K. Billmyer P.O. Box 401 W. Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 398X DUE TO, OR AS A CONSEQUENCE OF (b) Rheumatic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 WKS. 20 YRS. | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 416X | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 1963, to Jan 16, 1968, that (I) (we) last saw the deceased alive on Jan 16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Charles A. Hoffman | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED Jan 18, 68 | | |
| 22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | | | 22e. ADDRESS 214 N. Potomac St. Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 1/19/68 | | Rest Haven Cemetery | | Hagerstown Washington Md. | | |
| 24. FUNERAL DIRECTOR Wm. G. Horn | | | | 24a. REC'D BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | | |
| Rest Haven Funeral Chapel Hagerstown, Md. | | | | JAN 23 1968 | | Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|------------------------------|-----------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last EDWARD R HAMME | | | | | | 2a. DATE OF DEATH Month Day Year Jan 3 1968 | | | 2b. HOUR 3:24 A.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH March 7 1883 | | 6. AGE (In years last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Brodbecks Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWER <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Williamsport | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home | | 12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) Clergyman | | 12b. KIND OF BUSINESS OR INDUSTRY Pastor Professor | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Carroll | | 13c. CITY OR TOWN Westminster | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER R R #1 | | | |
| 14. FATHER'S NAME First Middle Last Ell G. Hamme | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Ann Rohrbaugh | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16b. SOCIAL SECURITY NO. 278-12-3156 | | 17. INFORMANT Address Rev Mark G. Wagner 2750 Virginia Ave | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis with Hemiplegia 412.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C.V. Dis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 mo. 8 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-1-66 to 1-3 , 19 68 , that (I) (we) lost the deceased alive on 12-28 19 67 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert P. Conrad | | DEGREE MD | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-3-68 | |
| 22d. PHYSICIAN'S NAME (Type) Robert P. Conrad | | 22e. ADDRESS 137 W. Washington Hagerstown, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/5/68 | | 23c. NAME OF CEMETERY OR CREMATORY St Jacobs Ch. Cemetery | | 23d. LOCATION (City or Town) (County) (State) Brodbecks York Co Pa. | | | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman | | Funeral Home Inc | | 25a. REC'D BY REGISTRAR JAN 5 1968 | | 25b. REGISTRAR'S SIGNATURE J Charles Judge | | | | | |

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STATE OF DEATH

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DATE OF DEATH

PLACE

AGE

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CAUSE OF DEATH

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TIME

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| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH Month <u>1</u> / Day <u>24</u> / Year <u>68</u> | | | 2b. HOUR <u>6:25</u> AM | |
| 3. SEX MALE | | | 4. RACE WHITE | | | 5. DATE OF BIRTH JANUARY 20, 1887 | | | 6. AGE (In years last birthday) 81 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH WASHINGTON Md. | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) RETIRED CONTRACTOR | | | 12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | | 13c. CITY OR TOWN HAGERSTOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 103 S. MONT VALLA AVENUE, | | | 14. FATHER'S NAME First ISAIAH Middle HAMMOND Last SARAH | | | 15. MOTHER'S MAIDEN NAME First SARAH Middle RIDENOUR Last RIDENOUR | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or, of unknown YES (If yes give war or dates of service) W.W. I | |
| 16b. SOCIAL SECURITY NO. 214-09-9862 | | | 17. INFORMANT MR. RICHARD K. HAMMOND, HAGERSTOWN, MARYLAND. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Central Aneurysm</u> <u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>4 hr.</u> <u>Years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) <u>the hospital</u> attended the deceased from <u>Dec 67</u> , 19 <u>67</u> , to <u>1/24</u> , 19 <u>68</u> , that (I) <u>XXX</u> last saw the deceased alive on <u>19</u> , and that in (my) <u>XXX</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>xxx</u> (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>J. D. Wilson</u> | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED <u>1/25/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) J. D. WILSON, M.D. | | | 22e. ADDRESS 580 NORTHERN AVE. HAGERSTOWN, MARYLAND. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 1/26/68 | | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MARYLAND | |
| 24. FUNERAL DIRECTOR <u>Charles M. Rayner</u> | | | HAGERSTOWN, MARYLAND. | | | 25a. REC'D BY REGISTRAR DATE JAN 29 1968 | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01720 | | | | | | | | | | | |
| 01711 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR M | | | |
| Virgie Mae Harper | | | | | | Jan 22 1968 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| Female | | Colored | | April 2 1889 | | 78 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Huyetts, Md | | USA | | | | Washington | | Private Family | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | |
| Hagerstown, Md | | 311 N. Jonathan St. | | Domestic | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission - STATE) | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Washington | | Hagerstown | | 311 N. Jonathan St. | | | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | |
| Calvin Harvey | | | Madeline Sanders | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| no | | | 178-16-5376 | | Miss Florence Goeins 311 N. Jonathan St. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Arrhythmia</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u> Months DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/17</u> , 19 <u>68</u> , to <u>1/17</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1/17</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>A. M. Mandell</u> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/23/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) A. M. MANDELL, M.D. | | | | | | 22e. ADDRESS 301 E. ANTIETAM STREET | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Jan 27 1968 | | Rose Hill Cemetery | | | Hagerstown Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR DATE | | 25b. REGISTRAR'S SIGNATURE | | | |
| John R. Watson Jr. Hagerstown Md. | | | | | | JAN 24 1968 | | <u>[Signature]</u> | | | |

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THESE MATERIALS ARE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--------------------------------|---|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last <i>Clarence Henry Harsh</i> | | | | | | 2a. DATE OF DEATH Month Day Year <i>Jan. 4 1968</i> | | | 2b. HOUR <i>4 P M</i> | | | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>April 10, 1900</i> | | | 6. AGE (In years last birthday) <i>67</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Washington, Co. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH <i>Washington</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Hagerstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>908 Maryland Ave.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Salesman</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Home Furnish.</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i> | | 13b. COUNTY <i>Washington</i> | | 13c. CITY OR TOWN <i>Hagerstown</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>908 Maryland Ave.</i> | | | | |
| 14. FATHER'S NAME First Middle Last <i>Charles Ashby Harsh</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>Anna Pittinger</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <i>214-09-8111</i> | | 17. INFORMANT Address <i>Mrs. Myrtle Beard 417 Indiana Ave. Hagerstown, Md.</i> | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4201</i> (b) <i>ARTERIOSCLEROTIC-HYPERTENSIVE C. V. DISEASE</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Several Years.</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>DIABETES MELLITUS</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10 June, 1963</i> , to <i>4 Jan, 1968</i> , that (I) (we) last saw the deceased alive on <i>20 Dec 1967</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE <i>W. N. FENDER</i> M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>6 Jan. 1968</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>W. N. FENDER</i> | | | | | | 22e. ADDRESS <i>218 N. Potomac St. Hagerstown, Md.</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/8/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Hagerstown Washington Md.</i> | | | | | | |
| 24. FUNERAL DIRECTOR <i>Wm. C. Hunt</i> <i>Rest Haven Funeral Chapel Hagerstown, Md.</i> | | | | 25a. REC'D BY REGISTRAR <i>JAN 10 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove top of pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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|--|--|---|--|--|--|---|--|
| 01722 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01713 | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) JESSIE M. HARWOOD | | | 2a. DATE OF DEATH Month Jan Day 6 Year 1968 | | | 2b. HOUR M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH May 27-1898 | | 6. AGE (In years last birthday) 69 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY _____ | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Frederick | | 13c. CITY OR TOWN Frederick | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER 112 W. Patrick St. | | | | | | | |
| 14. FATHER'S NAME First Clinton B.H. Middle Harwood Last Clinton B.H. Harwood | | | 15. MOTHER'S MAIDEN NAME First Dollie C. Middle Moore Last Dollie C. Moore | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | 16b. SOCIAL SECURITY NO. 215-42-3922 | | 17. INFORMANT Address Geo. M. Harwood- Braddock Hgts., Md. 21714 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma 1621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. 1621 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Carcinomatous metastases to pleura & diaphragm, liver metastases. | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 24 Jan , 19 67 , to 6 Jan , 19 68 , that (I) (we) last saw the deceased alive on 6 Jan , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Richard T. Binford MD. | | 22c. DATE SIGNED 8 Jan 68 | | 22d. PHYSICIAN'S NAME (Type) Richard T. Binford | | | |
| 22e. ADDRESS 1135 Potomac Ave Hagerstown | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan. 10-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery | | 23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701 | |
| 24. FUNERAL DIRECTOR M.R. Etchison & Son | | 24b. ADDRESS Frederick, Md. 21701 | | 25a. REC'D BY REGISTRAR JAN 10 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

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May 27-1898

U.S.A.

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Germany

International Trade

112. P. P. P. P.

Boiler & Engine

Wilmington & N. H. Railroad

May 27-1898 Wilmington & N. H. Railroad

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Wilmington & N. H. Railroad

May 27-1898

International Trade

Boiler & Engine

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|---------------------------|---|---|---|---|--|---|---|
| 01723 CERTIFICATE OF DEATH 01714 | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown | | | | c. LENGTH OF STAY IN 1b 21 Days | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Big Pool Maryland | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital | | | | | d. STREET ADDRESS R.F.D. 1 | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Hazel Delwood Hensley | | | First Middle Last | | 4. DATE OF DEATH Jan. 28 19 68 | | Month Day Year | | |
| 5. SEX Female | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH Aug. 21, 1911 | | 9. AGE (In years last birthday) 53 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (County & State, or foreign country) Washington Md. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME David Waterbaugh | | | | | 14. MOTHER'S MAIDEN NAME Laura Virginia Bowers | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Daisy Leasure RD2, Hag. Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 412.9 Ventricle fibrillation DUE TO (b) Coronary Artery Disease DUE TO (c) Atherosclerotic Heart Disease CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. 412.9 | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 20 days 6 mo 6 mo | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatic Heart Disease - Mitral Regurgitation + Cardiac Failure | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 25, 1968, to Jan 28, 1968, that (I) (we) last saw the deceased alive on Jan 28, 1968, and that death occurred at 1:00 PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Edna B. Moody | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE THEREOF Jan. 31, 68 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park | | 23d. LOCATION (City, town or county) (State) Hagerstown Md. | | |
| 24. FUNERAL DIRECTOR Donald E. Thompson | | | | | ADDRESS Thompson Funeral Home Clear Spring, Md. | | 25a. REC'D BY REGISTRAR FEB 2 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01724 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01715 | |
|---|------------------------------|--|--|---|-------------------------------------|--|--|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR |
| Mabel | | F. | | Hewitt | January 21, 1968 | | 2.15 PM |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | |
| Female | White | | Dec. 25, 1873 | | 94 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Baltimore | U. S. A. | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Williamsport | | Homewood Church Home | | House Wife | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | Baltimore | | Baltimore | | 2689 Dulany Street | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | |
| First Middle Lost | | First Middle Lost | | | | | |
| Marcelus | | Jones | | Not Known | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| No | | No | | 218-09-4512 Rev. Mark G. Wagner | | | |
| | | | | Address 2750 Va. Ave Williamsport, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Hypertensive Cr Dis</u> | | | | | | | 10 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (b) <u>Generalized Atherosclerosis</u> | | | | | | | 15 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 443X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>7-1</u> , 19 <u>67</u> , to <u>1-21</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-18</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | |
| Robert P. Conrad | | 1-22-68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | |
| Robert P. Conrad | | 1370 Washington Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | | Jan. 25/68 | | Loudon Park Cemetery | | Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Andrew K. Coffman Funeral Home Inc. | | | | JAN 23 1968 | | Charles Judge | |
| Hagerstown, Maryland | | | | DATE | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| PEARL | | | MARTHA HICKS | | | Jany 7 1968 | | A.M. 12.06 | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | |
| Female | | White | | May 17 1891 | | 76 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Paramount Md. | | USA | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Wash County Hospital | | | Housewife | | Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Hagerstown | | YES | | 714 No Potomac St | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Franklin Carl | | | | Florence Boward | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | None | | Jerry D. Hicks 714 No Potomac St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>4201</i> (b) <i>Coronary Atherosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2 days</i> <i>2 yrs</i> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Pericarditis Chronic - In Remission</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>2-11-1963</i> , to <i>1-7-1968</i> , that (I) (we) last saw the deceased alive on <i>1-7-1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Dalton M. Welty, M.D.</i> | | | | | 22c. DATE SIGNED <i>1/8/68</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type) <i>Dalton M. Welty, M.D.</i> | | | | | 22e. ADDRESS <i>998 Potomac Avenue, Hagerstown, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1/10/68 | | Rose Hill Cemetery | | Hagerstown Wash Co Md | | | | |
| 24. FUNERAL DIRECTOR <i>Hagerstown Md.</i> | | | | | 25a. REC'D BY REGISTRAR <i>JAN 11 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | |
| Andrew K. Coffman Funeral Home Inc | | | | | | | | | | |

01710

RECORD OF DEATH

01782

| | | | |
|-----------|--|------------|--|
| NAME | | DATE | |
| LAST | | MONTH | |
| FIRST | | DAY | |
| MIDDLE | | YEAR | |
| AGE | | SEX | |
| RACE | | RELIGION | |
| EDUCATION | | OCCUPATION | |
| MARRIAGE | | DEATH | |
| CAUSE | | PLACE | |
| DATE | | TIME | |
| SIGNATURE | | WITNESS | |
| DOCTOR | | CLERGY | |
| FAMILY | | FRIENDS | |
| BURIAL | | COST | |
| REMARKS | | OTHER | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|---|--|----------------------------|--|--|
| 01726 | | | | | 01717 | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| First Middle Last ODEN J. HILL | | | | | Jan. Month 7 Day 1968 | | | 7:24 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| MALE | | WHITE | | Nov. 19, 1880 | | 87 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| INDIANA | | USA | | | | WASHINGTON | | Mid | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | |
| HAGERSTOWN | | AVALON MANOR | | SALESMAN | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| W.Va. | | MORGAN | | BERKLEY SPRINGS | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | |
| JOHN W. HILL | | | | | EUNICE JESSEP | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| No | | 225-05-3375 | | E. PRESTON EVANS | | ARLINGTON, VA | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 3 yrs. 3 yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | Ten. | | Ten | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1968, to Jan. 7, 1968, that (I) (we) last saw the deceased alive on Jan 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Lloyd A. Hoffman DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/10/68 | | |
| 22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | | | | 22e. ADDRESS 214 N. Potomac St. Hagerstown | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-10-68 | | GREENWAY | | BERKLEY SPRINGS MORGAN W.Va | | | |
| 24. FUNERAL DIRECTOR Wm. H. Hunter - Berkley Springs, W.Va. | | | | | 25a. REC'D BY REGISTRAR JAN 11 1968 | | 25b. REGISTRAR'S SIGNATURE | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---|---|---|-------------------|--|---|--|--|---|-------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR M | | |
| Pearl | | | Mae | | Hoke | January 16, 1968 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | |
| Female | | White | | June 26, 1891 | | 76 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Virginia | | | | | | Washington, Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | Washington Co. Hospital | | | House Work | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 50 Elizabeth | | | Washington | | Hagerstown | | X | | 50 Elizabeth Street | | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Lost |
| Samuel Shifflett | | | | | | Louise Keller | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No | | | None | | | Grover Hoffman | | | 50 Elizabeth Street Hagerstown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Emphysema</u> 492x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. 5277 (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Atherosclerosis</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-16-66</u> , 19 <u>66</u> , to <u>1-16</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-16</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>A. M. Mandell, M.D.</u> | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1-17-68</u> | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| A. M. MANDELL, M.D. | | | | | | 301 E. ANTIETAM STREET, HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 1/20/68 | | Dieterick Cemetery | | Seven Fountain, Va. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Andrew K. Coffman, Funeral Home Inc. Hagerstown, Maryland. | | | | | | DATE JAN 19 1968 | | <u>Charles Judge</u> | | | |

MEDICAL CERTIFICATION

0192

0191

0190



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

01728

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01719

CERTIFICATE OF DEATH

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED-NAME (Type or print) May E. Hoover | | | 2a. DATE OF DEATH January 8, 1968 | | 2b. HOUR 11:30P |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH October 7, 1888 | | 6. AGE (In years last birthday) 79 YRS. | IF UNDER 1 YEAR MONTHS 3 DAYS 1 |
| 7a. BIRTHPLACE (State or foreign country) Wash. Co. Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Williamsport | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Homewood Church Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Rohrersville | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER ++++++ | |
| 14. FATHER'S NAME First Middle Last John Resler Haynes | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Elizabeth Poffenberger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 217-10-3166 | 17. INFORMANT Address Williamsport, Mark G. Wagner, 2750 Virginia Ave. Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive CV Dis 4120 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 year | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 443x | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 9, 1967 , to Jan 8, 1968 , that (I) (we) last saw the deceased alive on Jan 6, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Robert P. Conrad, MD | | DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 1-10-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Robert P. Conrad, MD | | 22e. ADDRESS 137 W. Washington Hagerstown, Md 21740 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-11-68 | 23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery | 23d. LOCATION (City or Town) (County) (State) Rohrersville, Maryland | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 12 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

01113

01113

January 8, 1958 11:30P

HOOPER

1

NY

October 1, 1957

White

Female

Washington

W. H. A.

seen. Co. W.

Woodward Church

Washington

Washington

Washington

Washington

John Rector Hayes

John Rector Hayes

21-10-100

Washington, D. C.

Washington, D. C.

1-11-58

21-11

Washington, D. C.

John Rector Hayes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

B.P.

VR A15 (4)
30M REV. 1/68

01729

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01720

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|---|--|---|---|---|--|---|---|---|-----------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First <i>Francis</i> | Middle <i>John</i> | Last <i>Hummer</i> | 2a. DATE OF DEATH Month <i>January</i> Day <i>8</i> Year <i>1968</i> | | | 2b. HOUR <i>9:04</i> M | |
| 3. SEX <i>Male</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>June 11, 1894</i> | | 6. AGE (In years last birthday) <i>73</i> YRS. | | IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) <i>Feed. Co. Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Washington</i> Md. | | | | |
| 10. CITY OR TOWN OF DEATH <i>Hagerstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Washington</i> | | 13c. CITY OR TOWN <i>Hagerstown</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER <i>R # 1</i> | | |
| 14. FATHER'S NAME First <i>John</i> Middle <i>H.F.</i> Last <i>Hummer</i> | | | 15. MOTHER'S MAIDEN NAME First <i>Alice</i> Middle <i>Ann</i> Last <i>Kurd</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. <i>213018-8886A</i> | | 17. INFORMANT Address <i>Mrs. Ethel L. Hummer R # 1 Hagerstown, Md.</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cancer of Rectum with metastasis</i> <i>1541</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mo.</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>1544 x</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-20, 1955</i> , to <i>1-8, 1968</i> , that (I) (we) last saw the deceased alive on <i>1-7, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <i>Charles F. Hess M.D.</i> | | | | | DEGREE <i>M.D.</i> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>1-9-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>Charles F. Hess M.D.</i> | | | | | 22e. ADDRESS <i>Smithsburg, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/10/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Hagerstown Washington Md.</i> | | | | |
| 24. FUNERAL DIRECTOR <i>Wm. A. Hest</i> <i>Rest Haven Funeral Chapel Hagerstown, Md.</i> | | | | | 25a. REC'D BY REGISTRAR <i>JAN 11 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01721

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED-NAME (Type or print) Grace Elizabeth Itnyre | | | 2a. DATE OF DEATH Month January Day 7 Year 1968 | | 2b. HOUR 3:00A M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH July 18, 1882 | | 6. AGE (In years last birthday) 85 YRS. | IF UNDER 1 YEAR MONTHS 5 DAYS 19 |
| 7a. BIRTHPLACE (State or foreign country) Boonsboro, Md. | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Boonsboro | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Reeder Nursing Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Boonsboro | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER S. Main St. Boonsboro, Md. | |
| 14. FATHER'S NAME First Middle Last Martin Smith | | 15. MOTHER'S MAIDEN NAME First Middle Last Susan Emmert | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 216-46-7262 | 17. INFORMANT Address Mr. Alvey Reid, Boonsboro, Maryland | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 440.9 arteriosclerotic vascular disease DUE TO, OR AS A CONSEQUENCE OF with paralysis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) thrombus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mon 4 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4500 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Oct 17, 1967 , to Jan 7, 1968 , that (I) (we) last saw the deceased alive on Jan 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE G.W. LeVan | | | | 22c. DATE SIGNED Jan 8, 1968 | |
| 22d. PHYSICIAN'S NAME (Type) G.W. LeVan | | | | 22e. ADDRESS Boonsboro, Md | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) Burial | | 23b. DATE 1- 9- 68 | | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md | | | 25a. REC'D BY REGISTRAR JAN 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles J. J... |

01731

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01722

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|----------------------------------|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY HAGERSTOWN <i>Washington</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY IN lb 28 YRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1025 MAIN AVE. | | | | d. STREET ADDRESS 1025 MAIN AVE. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First ORVILLE Middle ALEXANDER Last JOHNSON | | | | 4. DATE OF DEATH Month JANUARY Day 27 Year 1968 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/15/1917 | | 9. AGE (In years last birthday) 50 yrs. | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FREIGHT CONDUCTOR | | | 10b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME DANIEL GANT JOHNSON | | | | 14. MOTHER'S MAIDEN NAME FLORENCE FRENCH | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 705-12-8041 | | 17. INFORMANT MRS. JUANITA JOHNSON | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart disease 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial infarction DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 12 hrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201 | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 27 Jan , 19 68 , to 27 Jan , 19 68 , that (I) (we) last saw the deceased alive on 27 Jan , 19 68 , and that death occurred at 8 PM M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Elden S. Hoachler</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1/29/68 | |
| 22c. PHYSICIAN'S NAME (Type) Elden S. Hoachler | | | | 22d. ADDRESS Hagerstown Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM. | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. | |
| 24. FUNERAL DIRECTOR W. J. Harment | | | | ADDRESS Hagerstown Md. | | 25a. REC'D BY REGISTRAR DATE FEB 1 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|--|
| 01732 | | 01723 | |
| 1. DECEASED-NAME (Type or print) First Middle Last MARTIN LUTHER JONES | | | |
| 2a. DATE OF DEATH Month Day Year Jan. JANUARY 24 1968 | | 2b. HOUR 4:45 PM | |
| 3. SEX M | 4. RACE NEGRO | 5. DATE OF BIRTH Aug. 9, 1903 | 6. AGE (in years last birthday) 64 YRS. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH WASHINGTON Md. |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Orderly | 12b. KIND OF BUSINESS OR INDUSTRY Hospital |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY FREDERICK | 13c. CITY OR TOWN FREDERICK | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 13e. STREET AND NUMBER 428 MIDDLE ALLEY | 14. FATHER'S NAME First Middle Last MARTIN LUTHER JONES, Sr. | | |
| 15. MOTHER'S MAIDEN NAME First Middle Last Florence Walker | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) <input checked="" type="checkbox"/> No <input checked="" type="checkbox"/> | |
| 16b. SOCIAL SECURITY NO. 214-10-5458 | | 17. INFORMANT Address Catherine Jones 428 Middle St. Fred. Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive heart disease DUE TO, OR AS A CONSEQUENCE OF (c) several years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 443x Lobular pneumonia, cerebral vascular accident | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-28, 1967 , to 1-24, 1968 , that (I) (we) last saw the deceased alive on 1-23-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE OF PHYSICIAN Edwin G. Riley | | 22c. DATE SIGNED 1-24-68 | |
| 22d. PHYSICIAN'S NAME (Type) Edwin G. Riley | | 22e. ADDRESS 1500 Penna, Hagerstown, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-27-68 | 23c. NAME OF CEMETERY OR CREMATORY Fairview | 23d. LOCATION (City or Town) (County) (State) Frederick Fred. Md |
| 24. FUNERAL DIRECTOR C.F. Hicks, 111 Frederick, Maryland | | 25a. REC'D BY REGISTRAR JAN 26 1968 | 25b. REGISTRAR'S SIGNATURE James Judge |

01730

01730

Primary embolus
Hypertensive heart disease

lobular pneumonia, central vascular sclerosis

1-28-07 1-24-08

1500 Penn, Hagerstown, Md
1-24-08

Chas H. Baker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 01733 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01724 | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last MERI KINCSES | | | | | | | | | | 2a. DATE OF DEATH Month Day Year JAN. 1 1968 | | | | | | | | | | 2b. HOUR 9:10 P M | | | | | | | | | | | | | | |
| 3. SEX FEMALE | | | | | 4. RACE WHITE | | | | | 5. DATE OF BIRTH FEBRUARY 15, 1894 | | | | | 6. AGE (In years last birthday) 73 YRS. | | | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | IF UNDER 24 HRS. HOURS MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) HUNGARY | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER | | | | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | | | 13b. COUNTY WASHINGTON | | | | | 13c. CITY OR TOWN HAGERSTOWN | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER 337 BROOKLINE AVENUE | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last JOSEPH BACSA | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last BARBARA LASZLO | | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service) **** | | | | | | | | | | 16b. SOCIAL SECURITY NO. 213-10-6813D | | | | | 17. INFORMANT Address MRS. HELEN BROWN, 337 BROOKLINE AVE. HAGERSTOWN, MD | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4201</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (we) (hospital) attended the deceased from <u>1955</u> , 19____, to <u>1/6/68</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/6/68</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert V. L. Campbell</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | | | | | | 22c. DATE SIGNED 1/8/68 | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) ROBERT V. L. CAMPBELL, M.D. | | | | | | | | | | | | | | | 22e. ADDRESS 145 W. WASHINGTON ST. HAGERSTOWN, MD. | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | | | 23b. DATE 1/9/68 | | | | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY, | | | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Wilson L. Eschbacher</u> HAGERSTOWN, MARYLAND. | | | | | | | | | | | | | | | 25a. REC'D BY-REGISTRAR DATE JAN 11 1968 | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u> | | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| William Brown Leatherman | | | | | | January 1, 1968 | | | 11 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| Male | | White | | June 6, 1876 | | | 91 YRS. | | 6 25 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md. Manor Wash. Co. | | U. S. A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | Washington Co. Hospital | | | Farmer | | | Farming |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Washington | | Boonsboro | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rfd. 1 Manor Church Rd. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Jacob Leatherman | | | Mary Elizabeth Brown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No. | | | 220-34-0822 | | Mr. Lloyd Y. Leatherman Rfd. 1, Boonsboro, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobar pneumonia</u> <u>481X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | 48 Hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>490X Congestive Heart failure -</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-15</u> , 19 <u>61</u> , to <u>1-1</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>1-1</u> , 19 <u>68</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph Secondary</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1-2-68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u> | | | | | 22e. ADDRESS <u>BOONSBORO MD 21713</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 1-3-68 | | Manor Cemetery | | | Tilghmanton, Wash. Co., Md. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | DATE JAN 5 1968 | | <u>Charles Judge</u> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

| | | | | | | | | | | | |
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| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR A M | | | | |
| DAVID | | ALEXANDER | LINDSAY | | Jany 4 1968 | | 8.30 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| Male | | White | | Dec 19 1891 | | 76 | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Maryland | | USA | | | | Washington | | Md | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| Hagerstown | | Wash County Hospital | | Pharmacist | | Drug | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | Washington | | Hagerstown | | 839 Frederick St | | | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| Matthew W. Lindsay | | | | | E. Gertrude Brewer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT | | Address | | | | | |
| No | | 217-09-9716 | | George R. Lindsay | | Hagerstown Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>5900</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic Pyelonephritis</u> (b) <u>Chronic Pyelonephritis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Pyelonephritis</u> | | P.O. Box # 555 | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>Not known</u> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>6000</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Arthur Riego</u> | | DEGREE | | ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/5/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | | | |
| ARTHUR RIEGO | | 119 E. Antietam St. Hagerstown | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 1/8/68 | | Rose Hill Cemetery | | Hagerstown | | Wash Co | | Md. | |
| 24. FUNERAL DIRECTOR | | Hagerstown Md | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Andrew K. Coffman | | Funeral Home Inc | | DATE | | JAN 9 1968 | | Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

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|--|--|--|--|--|--|--|--|--|--|----------------------------|--|
| MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 01736 | | | | | | | | | | | |
| 01727 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| First Middle Last | | | | Month Day Year | | | | 9:48 M | | | |
| AGNES MARIE LITTLE | | | | January 27 68 | | | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| FEMALE | | WHITE | | 8-29-08 | | 39 YRS. | | MONTHS DAYS | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Ranson W. Va. | | U.S. | | | | WASHINGTON Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| HAGERSTOWN | | WESTERN MD. STATE HOSPITAL | | HOUSE WIFE | | Own home | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| MARYLAND | | Washington | | HAGERSTOWN | | | | Northampton Apts. 48 Longmeadow Apts. | | | |
| 14. FATHER'S NAME First Middle Last | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| OSCAR HAMILTON TILLEY | | | | DORA FRANCES GOLADY | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | | 219-46-3363 | | J.W. Little 4504 Kerby Pkwy. Washington, D.C. 20022 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Carcinoma of the breast with metastasis 2 yrs. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 170X | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 8, 1967, to Jan. 27, 1968, that (I) (we) last saw the deceased alive on Jan. 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Fe U. Poreianca M.D. | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED Jan. 27, 1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) FE U. POREIANCA LA | | | | 22e. ADDRESS Western Maryland State Hosp. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 1/29/68 | | Rest Haven Cemetery | | Hagerstown Washington Md. | | | | | |
| 24. FUNERAL DIRECTOR Wm. A. Hovak | | | | ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Rest Haven Funeral Chapel Hagerstown, Md. | | | | | | | | DATE JAN 30 1968 | | James Judge | |

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WASHINGTON

WASHINGTON

WESTERN U.S. STATE NATIONAL

WASHINGTON

John C. ...

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|------------------------------|--|--|------------------|--|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| Donald Richard Lockard | | | | | | January 3, 1968 | | | 12:00 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | | 2d. HOUR |
| Male | White | November 17, 1931 | 36 | 1 MONTHS | 16 DAYS | 1 Day 3 Year 1968 | | | 12:00 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| Hanover, Penna | | U. S. A. | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. KIND OF BUSINESS OR INDUSTRY | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | Washington Co. Hospital | | | Accountant | | | Trucking |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| Maryland | | | Washington | | | Funkstown | | | 36 W. Baltimore St. |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Carroll Lockard | | | Agnes Watson | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT ADDRESS | | | |
| yes | | | Korean | | | Mrs. Ina M. Lockard, 36 W. Baltimore St. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Aneurysm Of Rt. Middle Cerebral Artery Ruptured</u> | | | | | | | | | 7 days |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) <u>Subarachnoid Hemorrhage</u> | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) <u>Early Lobular Pneumonia Rt. Lower Lobe.</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 330x | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | 19 | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | 1-5-68 | | | |
| Dr. E. W. Ditto, Jr. | | | 22c. WASHINGTON ST., HAGERSTOWN, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1-6-68 | | Rest Haven Cemetery | | Hagerstown, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | |
| John H. Bast, Jr. 112 North Main St. Boonsboro Maryland | | | DATE JAN 9 1968 | | | Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

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CERTIFICATE OF DEATH

01729

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|---|--|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN lb LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | d. STREET ADDRESS 241½ E. FRANKLIN ST. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First Middle Last PAMELA SUE LYNN | | | 4. DATE OF DEATH Month Day Year JANUARY 30 1968 | | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH 1/29/68 | | 9. AGE (In years last birthday) yrs. 1 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | |
| 13. FATHER'S NAME UNKNOWN | | | 14. MOTHER'S MAIDEN NAME CORA MAE LYNN | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. NONE | | 17. INFORMANT MRS. CORA M. LYNN | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pending autopsy Pneumonia & hyaline DUE TO membrane disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH from birth | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 7630 Laceration of liver & Rt. adrenal gland hemorrhage | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <i>Howard N. Weeks</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1/31/68 | |
| 22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M. D. | | 22d. ADDRESS 580 Northern Avenue Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE THEREOF 2/1/68 | 23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. GARDENS HAGERSTOWN | | 23d. LOCATION (City or town) (County) (State) MD. | |
| 24. FUNERAL DIRECTOR <i>W. J. Normant, Hagerstown, Md.</i> | | 25a. REC'D BY REGISTRAR DATE FEB 7 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 01730 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Hattie (NMN) Madison | | | | | 2a. DATE OF DEATH Month Day Year 10:15 Jan 18 1968 A M | | | | |
| 3. SEX Female | | 4. RACE Colored | | 5. DATE OF BIRTH Aug 25 1893 | | 6. AGE (In years lost birthday) 74 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Richmond Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY Private Fam | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 225 1/2 N Jonathan St | |
| 14. FATHER'S NAME First Middle Last Dave Madison | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Unknown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO. none | | 17. INFORMANT Address Arnetta Hunter 54 Blooms Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary occlusion 10-15 minutes DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Arteriosclerotic heart disease Indefinite DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pneumonitis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 10, 1968, to Jan. 18, 1968, that (I) (we) last saw the deceased alive on Jan. 17, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE B. B. Kneisley, M.D. | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/22/68 | | |
| 22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D. | | | | | 22e. ADDRESS 148 West Washington Street Hagerstown, Maryland | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-22-1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Maryland | | | |
| 24. FUNERAL DIRECTOR John R Watson Jr Hagerstown Md | | | | | 25a. REC'D BY REGISTRAR DATE JAN 23 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------------|---|--|---|---------------------------------------|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01740 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY IN lb LIFE | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | | | | d. STREET ADDRESS 277 S. POTOMAC ST. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last ALICE EVANGALINE MARTIN | | | | | 4. DATE OF DEATH Month Day Year JANUARY 10 19 68 | | | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10/21/1900 | | 9. AGE (In years last birthday) yrs. 67 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME CONRAD L. WAGNER | | | | | 14. MOTHER'S MAIDEN NAME MARY HACKETT | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT MRS. GERALDINE JONES MD. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema DUE TO (b) Acute coronary occlusion DUE TO (c) Coronary arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 45 min 45 min Unk | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis, scoliosis | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan 7, 1968 , to Jan 10, 1968 , that (I) (we) last saw the deceased alive on Jan 10, 1968 , and that death occurred at 2:37 PM , from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE L L Packer, Jr. | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED 1/10/68 | | | |
| 22c. PHYSICIAN'S NAME (Type) L. L. Packer, Jr., M. D. | | | | | 22d. ADDRESS 145 West Washington Street | | | | | | |
| 23a. BURIAL, CREMATION, REBURY BURIAL | | 23b. DATE THEREOF 1/12/68 | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM. | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. | | | | |
| 24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE P. Charles Jones | | | | |

CERTIFICATE OF DEATH

01742

01732

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>wash.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>wash.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> | | c. LENGTH OF STAY IN TB — | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RD6 - Hagerstown, md.</u> | | d. STREET ADDRESS <u>RD6 - Hagerstown, md.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Edna Grace Martin</u> | | 4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>1968</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/9/1899</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Cearfoss, md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Victor Cunningham</u> | | 14. MOTHER'S MAIDEN NAME <u>Lulu Smith</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>213-42-1225</u> | |
| 17. INFORMANT <u>J. D. Earl Martin - Hagerstown, md.</u> | | Address <u>RD6</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>431.0 Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>331X</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/23</u> , 19 <u>68</u> , to <u>11/31</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>11/31</u> , 19 <u>68</u> , and that death occurred at <u>3:45 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Donald E. Martin</u> M.D. | | 22b. DATE SIGNED <u>11/31/68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DONALD E. MARTIN</u> | | 22d. ADDRESS <u>HAGERSTOWN, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u> | 23b. DATE THEREOF <u>2/3/68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ruff Church Cem.</u> | 23d. LOCATION (City or Town) (County) (State) <u>Cearfoss md.</u> |
| 24. FUNERAL DIRECTOR <u>A.E. Munnich - Greencastle, Pa.</u> | | 25a. REC'D BY REGISTRAR DATE <u>FEB 2 1968</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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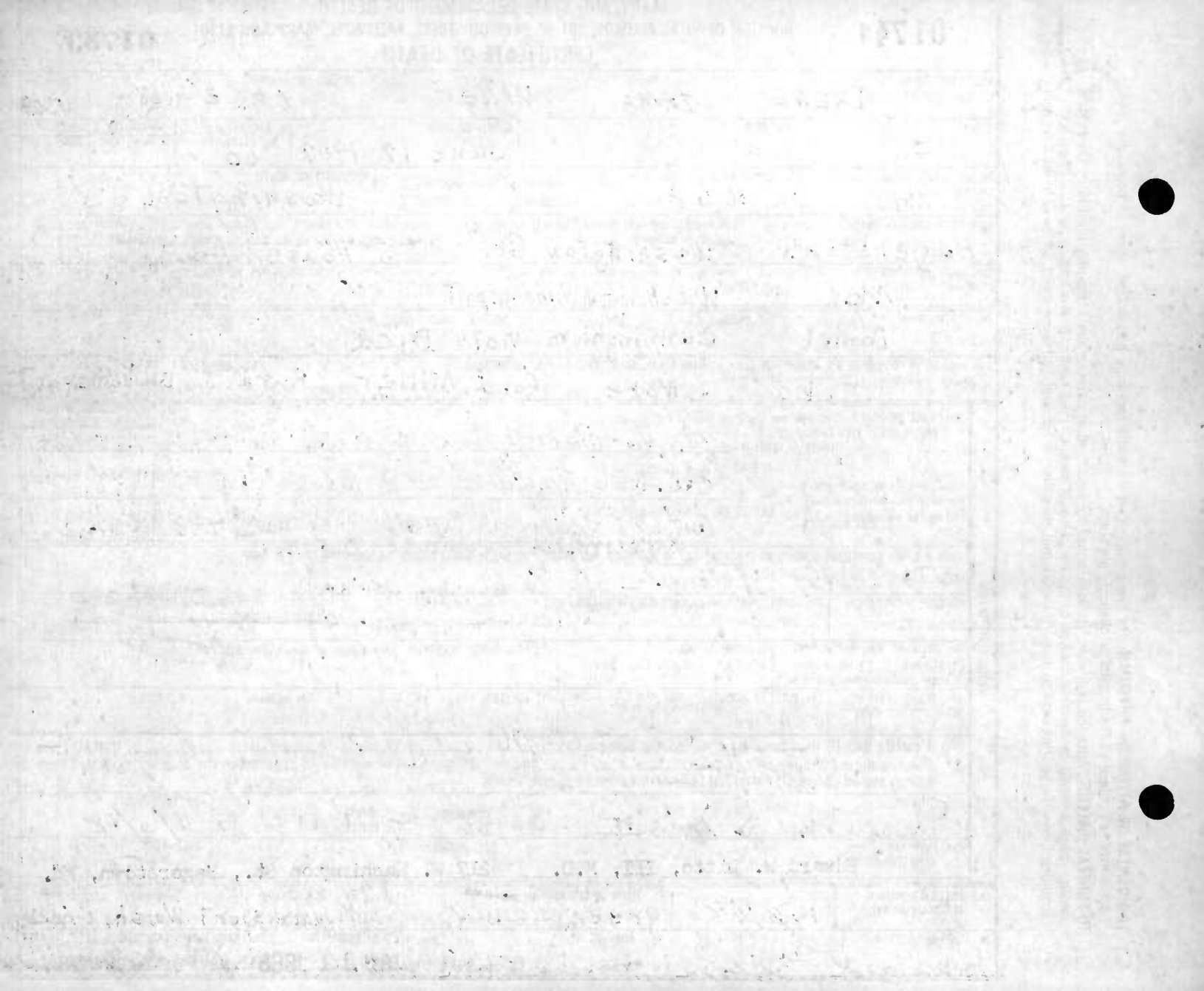
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|--|---|---|---|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) IRENE IRMA Miller | | | | | 2a. DATE OF DEATH 1 Month 3 Day 68 Year | | 2b. HOUR 4:30 AM | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH June 17 1907 | | 6. AGE (in years last birthday) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Williamsport | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last Daniel Cunningham | | | 15. MOTHER'S MAIDEN NAME First Middle Last Viola Dick | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Rox L. Miller | | Address Rural J. Williamsport Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Pulmonary Edema + 4120 DUE TO, OR AS A CONSEQUENCE OF (b) Cardiac failure due advanced DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease 443x APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs. 25 yrs | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Diabetes Mellitus & Hagerman obesity | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Aug 15 , 19 67 , to _____, 19____, that (I) (we) last saw the deceased alive on Jan 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Edward W. Ditto III | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/5/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D. | | | | 22e. ADDRESS 217 W. Washington St., Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE 1/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY Green Lawn | | 23d. LOCATION (City or Town) (County) (State) Williamsport Wash. Md. | | | | |
| 24. FUNERAL DIRECTOR Howard J. Lane | | | | ADDRESS Hancock Md | | 25a. REC'D BY REGISTRAR DATE JAN 11 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Jones | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|---------------------------------|--|--|--|
| 01743 | | | | | 01734 | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| George Dere Moats | | | | | January 29 1968 | | | | | 11:24 AM | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | | White | | May 25, 1896 | | | 71 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH | | | |
| Dilghmantion | | | USA | | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | 300 S. Monta Valla Ave. | | | Sheet Metal | | | Cold Storage | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Hagerstown | | | | 300 S. Monta Valla Ave. | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| George W Moats | | | Anna Rebecca Rohrer | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| Yes | | | 214-09-4487 | | Mrs. G.D. Moats 300 S. Monta Valla Ave. Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Coronary Thrombosis | | | | | | | | | | 30 min | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C.V. Dis | | | | | | | | | | 6 yrs | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1, 1965, to 1-29, 1968, that (I) (we) last saw the deceased alive on 1-3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | | | | | | |
| Robert P. Conrad | | | 1-30-68 | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | | | |
| Robert P. Conrad | | | 137 W. Washington Hagerstown, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | | 2/1/68 | | Rest Haven Cemetery | | Hagerstown-Washington Md. | | | | |
| 24. FUNERAL DIRECTOR | | | 24b. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Wm. G. Harst | | | Hagerstown, Md. | | FEB 1 1968 | | Charles Judge | | | | |
| Rest Haven Funeral Chapel | | | | | | | | | | | |

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W. S. Hart

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01735

| | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|--|--|---|--|
| 1. DECEASED-NAME (Type or print) Alvey Columbus Morgan | | | 2a. DATE OF DEATH January 14, 1968 | | | 2b. HOUR 7:00 P.M. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH October 18, 1892 | | 6. AGE (In years last birthday) 75 YRS. | | IF UNDER 1 YEAR MONTHS 2 DAYS 26 | | IF UNDER 24 HRS. HOURS 2 MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Boonsboro, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 809 Florida Ave. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 809 Florida Ave. | | | |
| 14. FATHER'S NAME First Middle Last John Morgan | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Florence Furry | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. 716-10-1102 | | 17. INFORMANT Hagerstown, Md. Mr. Sherman L. Morgan, 809 Florida Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor. heart failure 4129 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (c) myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Emphysema, brachial artery obstruction etc. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, etc.) Office building, etc. | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-19 , 19 63 , to death 19 67 , that (I) (we) last saw the deceased alive on 4-13 19 67 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert F. Keadle | | | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-16-67 | | | |
| 22d. PHYSICIAN'S NAME (Type) Robert F. Keadle, M. D. | | | | 22e. ADDRESS Hagerstown Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-17-68 | | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | | 23d. LOCATION (City or Town) (County) (State) Boonsboro, Maryland | | | | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

01746

STATE OF TEXAS

01746

Alvey, Columbia, Herman, January 11, 1950, 1:00P

Life, White, October 18, 1952, 2:30

McCord, M., U. S. A., Washington

Hagerstown, 609 Florida Ave., Engineer, Railroad

Washington, Hagerstown, 609 Florida Ave.,

John K. H., Florence, Hagerstown, Md.

11-1-1952, Dr. Stephen L. Norton, 609 Florida Ave.

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

Washington, Md.,

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|----------|---|---|--|--|---|-------------------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First | Middle | Last | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR | |
| | | | Nellie | Mae | Nave | Jan 1 19 68 | | 2P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | | 2c. DATE PRONOUNCED DEAD Month Day Year | | 2d. HOUR |
| Female | White | Sept. 5, 1888 | | 79 YRS. | | | Jan 1, 19 68 | | 2P. M |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Front Royal, Va. | | USA | | | | | Washington | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | Avalon Manor Nursing Home | | | | Housewife-Seamstress | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Washington | | Hagerstown | | | | 313 S. Cannon Ave. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| | | | Nicholis | Nathaniel | Wood | Jexanna | | | Ralls |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | 220-16-1793 | | Mrs. Ruth Spalding 313 S. Cannon Ave. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fracture Of Humerus</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Several years 10 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 260X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. Dec. 21, 19 67 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Fell from commode seat. | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home | | 21f. LOCATION Street or R.F.D. No. City or Town County State 313 S. Cannon Ave., Hagerstown, Washington Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED 1-2-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE 1/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Washington Md. | |
| 24. FUNERAL DIRECTOR Rest Haven Funeral Chapel | | | | ADDRESS Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 4 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

U.S. DEPT. OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

100-100000

RECEIVED BY THE BUREAU OF INVESTIGATION

100-100000

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows]

[Illegible text follows]

[Illegible text follows]

W. B. [Illegible]
[Illegible text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01746

01737

| | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|-------------------------------|--|
| 1. DECEASED-NAME (Type or print) DAVIS | | | First Middle Lost WILBUR NEWCOMER | | | 2a. DATE OF DEATH January Month 13 , Day 1968 | | | 2b. HOUR 7:30 AM | | | | | | |
| 3. SEX Male | | | 4. RACE White | | | 5. DATE OF BIRTH Feb. 11, 1890 | | | 6. AGE (In years lost birthday) 77 YRS. | | | IF UNDER 1 YEAR MONTHS 11 DAYS 2 | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH Washington | | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Williamsport | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 2769 Virginia Ave. Ext. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Banker | | | 12b. KIND OF BUSINESS OR INDUSTRY Banking | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. CITY OR TOWN Washington | | | 13c. CITY OR TOWN Williamsport | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER 2769 Virginia Ave. Ext. | | | |
| 14. FATHER'S NAME First Middle Lost Franklin Davis Newcomer | | | 15. MOTHER'S MAIDEN NAME First Middle Lost Amelia Landis | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 212-03-2187 | | | 17. INFORMANT Mrs. Nancy Newcomer | | | 2769 Virginia Ave. | | | Williamsport, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Atherosclerotic Heart Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4201</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 years</u> | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Psychoneurosis -</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>6-7-56</u> , 19 <u>56</u> to <u>1-13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-8</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Dalton M. Welty, M.D.</u> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 1-15-69 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Dalton M. Welty M.D. | | | | | | 22e. ADDRESS 998 Potomac Ave. Hagerstown, Maryland | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE Jan. 15, 1968 | | | 23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Near Clearspring, Wash., Maryland | | | | | | |
| 24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Maryland | | | | | | 25a. REC'D BY REGISTRAR JAN 19 1968 DATE | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | |

01756

01756

01756

DATE: 12/11/50 TIME: 10:00 AM

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

CERTIFICATE OF DEATH

01738

| | | | | | | | | |
|--|---------|--|------------------|--|---------------------------------|--|------------------------|--|
| 1. DECEASED-NAME (Type or print) | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | |
| Ruth | | Virginia | Newkirk | Jan. 19, 1968 | | 2 A | | M |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | White | | Feb. 11, 1911 | | 56 | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Big Spring | | U.S.A. | | | | Washington Md. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown, Md. | | Avalon Manor | | House work | | Home duties | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission), STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Maryland | | Washington | | Big Spring | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | None |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | First | | Middle | | Last |
| Harry | | Blanche | | # | | # | | Sibert |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | None | | 214-34-7558 | | Harry Newkirk Big Spring, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | 1 year |
| IMMEDIATE CAUSE (a) <u>Adenocarcinoma, Recto-sigmoid colon</u> | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | |
| (b) | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 1540 | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 3/15/67 | | Adenocarcinoma recto-sigmoid | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | City or Town | | County State |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | Street or R.F.D. No. | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/18/67</u> , 19 <u>67</u> , to <u>1/19</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>December</u> <u>1967</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| John H. Kehne | | 1/19/68 | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | |
| John H. Kehne, M.D. | | 1229 Ravenwood Heights, Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | 1/21/68 | | Rose Hill Cem. | | Clear Spring, Md. | | |
| 24. FUNERAL DIRECTOR | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Margaret Rowland | | DATE JAN 23 1968 | | Charles Judge | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

[Signature]

CERTIFICATE OF DEATH

01739

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pa. b. COUNTY Franklin | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | c. LENGTH OF STAY IN Tb 17 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Theresa Middle Katherine Last Newman | | 4. DATE OF DEATH Month Jan. Day 30 Year 1968 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 10/20/1885 |
| 9. AGE (In years last birthday) yrs. 82 | | 10. IF UNDER 1 YEAR Months Days Hours Min. 0 0 0 0 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Duties | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) Lewisburg, Pa. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Jacob F. Newman | | 14. MOTHER'S MAIDEN NAME Emma Frantz | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Wilford L. Harbaugh, Waynesboro Pa. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) abdominal carcinomatous DUE TO (b) prob. from carcinoma of stomach DUE TO (c) 151X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) hypertension and hypertensive heart disease | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 1964 , 19__, to death , 19__, that (I) (we) last saw the deceased alive on 29 Jan 1968 , and that death occurred at __ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE John C. Stauffer M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) John C. Stauffer | | 22d. ADDRESS 115 S. Prospect St., Hagerstown Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 2/1/68 | 23c. NAME OF CEMETERY OR CREMATORY Green Hill | 23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin Co., Pa. |
| 24. FUNERAL DIRECTOR Walter Y. Grove | | ADDRESS Waynesboro Pa. | 25a. REC'D BY REGISTRAR FEB 2 1968 |
| | | 25b. REGISTRAR'S SIGNATURE James J. Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|---|---|---|---|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF DEATH | |
| CHARLES EDWARD NOLAND Sr | | | | | | | | <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input checked="" type="checkbox"/> JAN 3 1968 | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | | 2c. DATE PRONOUNCED DEAD |
| Male | White | Jany 6 1921 | | 46 YRS. | | | | | Month Day Year Jany 3 1968 19 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Mordue W. Va. | | USA | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Wash County Hospital | | | Construction | | Steel | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| Maryland | | | Washington | | Hagerstown | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 330 Radoliffe Ave |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| Paul I. Noland | | | Beulah Moser | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| Yes | | | W.W.#2 | | 330-20-7285 Mrs Laura M. Noland 330 Radoliffe Ave | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Advanced atherosclerotic heart</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Disease</u> | | | | | | | | | Trained 15-20 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| CAUSE OF DEATH | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | EXAMINER'S NAME (Type) | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED | |
| Edward W. Dittus III | | | | | | | | 1/5/68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/6/68 | | Rest Haven Cemetery | | Hagerstown Wash Co Md | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Andrew K. Coffman Funeral Home Inc | | | | DATE JAN 9 1968 | | Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01741

| | | | | | | | | | | | |
|---|--|---------|---|------------------|---|--|---|---|---|-------------------------------|---|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR M | | |
| Lee | | | | All | Oswald | Jan. 2 1968 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN | |
| Male | | White | | Sept. 18, 1873 | | 94 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Md. USA Washington Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Washington County Hospital | | | Farmer | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Md. | | | Wash. | | Smithsburg | | | | RD# 1 Smithsburg | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Benjamin | | | | | Oswald | Sophia | | | | | Bell |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | |
| No | | | 217-09-1792B | | | Wilmer E. Oswald, RD# 1, Smithsburg, Md. 21783 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure | | | | | | | | | | | 12-7-67 |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardiovascular disease | | | | | | | | | | | (3 weeks) |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | 10 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | | |
| 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town | | County State |
| 22a. I certify that (I) (this hospital) attended the deceased from 6-23-64 to 1-2 1968, that (I) (we) last saw the deceased alive on 1-2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Charles F. Hess | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 1-3-68 | | |
| 22d. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D. | | | | | | 22e. ADDRESS Smithsburg, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | Jan. 5, 1968 | | Smithsburg Cemetery | | | Smithsburg Washington Md. | | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Md. | | | | | | 25a. REC'D BY REGISTRAR JAN 5 1968 | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 01751 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01742 | |
|--|--|--|-------------------|---|---|--|-----------------------------|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) <i>Nelsie</i> | | | First Middle Lost | | 2a. DATE OF DEATH <i>JAN.</i> Month <i>18</i> Day <i>1968</i> Year | | 2b. HOUR <i>11:45</i> AM |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>MAY 28, 1882</i> | | 6. AGE (In years lost birthday) <i>85</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country) <i>Baltimore, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>United States</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Washington County</i> Md. | |
| 10. CITY OR TOWN OF DEATH <i>Williamsport</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Williamsport Sanitarium</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>PENNSYLVANIA</i> | | 13b. COUNTY <i>Franklin</i> | | 13c. CITY OR TOWN <i>Blue Ridge Summit</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME <i>Thomas</i> | | First Middle Lost | | 15. MOTHER'S MAIDEN NAME <i>Keefee, Catharine</i> | | First Middle Lost | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>188-36-4364</i> | | 17. INFORMANT <i>Mrs. Wm. T. Manahan</i> Address <i>Blue Ridge Summit Pa</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia bilateral (viral?)</i> <i>480X</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <i>490X</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Congestive heart failure</i> | | | | | | | |
| 19a. DATE OF OPERATION <i>None</i> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. _____ Month _____ Day _____ Year _____ P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.D. No. _____ City or Town _____ County _____ State _____ | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Apr. 23, 1963</i> , to <i>Jan</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>Jan. 14</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>M.E. Byrkit</i> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <i>1-19-68</i> | |
| 22d. PHYSICIAN'S NAME (Type) <i>M.E. Byrkit M.D.</i> | | | | 22e. ADDRESS <i>28 West Potomac St. Williamsport, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1-22-68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Frederick, Md. Fred. Co</i> | |
| 24. FUNERAL DIRECTOR <i>Raymond E. Creager</i> | | | | ADDRESS <i>Thurmont, Md.</i> | | 25a. REC'D BY REGISTRAR <i>Jan 23 1968</i> | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE <i>James J. Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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30M REV. 1/68

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|--|--|--|---|---|--|--|--|
| 01752 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01743 | |
| Item 5 Film G397 1/24/68 kk | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last Helen Regina Pendergast | | | 2a. DATE OF DEATH JANUARY Month 11 Day 1968 Year | | | 2b. HOUR 4:30 A M | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH Jan 12-9-86 | | 6. AGE (In years lost birthday) 82 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) Washington DC | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Montgomery | | 13c. CITY OR TOWN Barnesville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER | | 14. FATHER'S NAME First Middle Last Harry Hegarty | | 15. MOTHER'S MAIDEN NAME First Middle Last Bridget Kingston | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mrs. Katherine Simmons | | Address 5712 Stillwell Rd | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 203X DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Multiple myeloma APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 203X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | 22a. I certify that (I) (this hospital) attended the deceased from 11-9-67, to 1-11-68, that (I) (we) lost saw the deceased alive on 1-10-68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | |
| 22b. SIGNATURE Clum G Paley M.D. | | 22c. DATE SIGNED 1-11-68 | | 22d. PHYSICIAN'S NAME (Type) Clum G Paley | | 22e. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Marys | | 23d. LOCATION (City or Town) (County) (State) Barnesville Montgomery Md | |
| 24. FUNERAL DIRECTOR Constance C Hilton | | 25a. REC'D BY REGISTRAR JAN 16 1968 | | 25b. REGISTRAR'S SIGNATURE Phyllis Judge | | 25c. DATE | |

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Multiple myeloma

11-1 11-1 11-1

Chlorine Dioxide

in

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01753

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01744

| | | | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|---|--|--|--|---|-----------------|--------------------------------|--|--|--|--------------------------------------|------------|--|--|--|--|
| 1. DECEASED-NAME (Type or Print) | | | First George | | | Middle Clayton | | | Last Rickard | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year Jan. 20, 1968 | | | 4:10 P. M. | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Dec. 29, 1883 | | 6. AGE (In years last birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD Month Day Year Jan. 20, 1968 | | | 8:15 P. M. | | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH Washington Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH RD1, Clear Spring | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | | | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | | 13b. COUNTY Washington | | | | 13c. CITY OR TOWN Clear Spring | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER R. F. D. 1 | | | | | |
| 14. FATHER'S NAME First Middle Last Francis Rickard | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Mary Catharyn Palmer | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-01-9898A | | | | 17. INFORMANT Edward Rickard Clear Spring, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4221</u> | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>A. E. W. Ditto, Jr.</u> | | | | EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | | | 22b. DATE SIGNED 1-22-68 | | | | 22c. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE Jan. 23, 68 | | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill | | | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR Donald E. Thompson | | | | 25a. REC'D BY REGISTRAR DATE JAN 24 1968 | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | | | | | | | | |

CERTIFICATE OF DEATH

01754

01745

| | | | | | | | |
|---|----------------------------------|---|---|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> | | | c. LENGTH OF STAY IN TB <u>23 Days</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Smithsburg</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co. Hospital</u> | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Sarah E. Ridenour</u> | | First Middle Last | | 4. DATE OF DEATH <u>Jan. 15 19 68</u> | | Month Day Year | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/7/1885</u> | | 9. AGE (In years lost birthday) <u>82 yrs.</u> | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Keedysville, Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Lewis Kindle</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary J. Churchey</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>216-54-8685</u> | | 17. INFORMANT <u>Mrs. Henry Bishop, Smithsburg Md., #3</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>10 years</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4221</u> | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>5-11</u> , 19 <u>55</u> , to <u>1-14</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-14</u> 19 <u>68</u> , and that death occurred at <u>2:50 PM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>Charles F. Hess</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>1-16-68</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M.D.</u> | | | | 22d. ADDRESS <u>Smithsburg, Maryland 21783</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>1/17/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Smithsburg Washington Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Walter Y. Grove</u> | | | | ADDRESS <u>Waynesboro Pa.</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 19 1968</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

07710

RECEIVED OF 07710

07710



07710-0101

01755

CERTIFICATE OF DEATH

01746

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY in 1b 60 YRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 S. CANNON AVE. | | | | d. STREET ADDRESS 300 S. CANNON AVE. | | e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY ROHRER | | | | 4. DATE OF DEATH Month Day Year JANUARY 27 1968 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/20/1897 | | 9. AGE (In years last birthday) yrs. 71 | IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED ORDERLY | | | 10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL | | 11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JOHN HENRY ROHRER | | | | 14. MOTHER'S MAIDEN NAME MARGARET L. LONG | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-30-9849A | | 17. INFORMANT Address HAGERSTOWN MRS. MARGARET L. ROHRER MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO (b) Arteriosclerotic heart disease DUE TO (c) 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4500 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH upstairs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes mellitus; arteriosclerosis generalized | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour : a.m. : p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 4-10, 1963 to death , that (I) (we) last saw the deceased alive on Jan 24 1968 and that death occurred at 04 M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Robert F. Keadle M.D. | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1-27-68 | |
| 22c. PHYSICIAN'S NAME (Type) Robert F Keadle | | | | 22d. ADDRESS Hagerstown Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1/30/68 | | 23c. NAME OF CEMETERY OR CREMATORY LEITERSBURG LUTHERN | | 23d. LOCATION (City or Town) (County) (State) LEITERSBURG WASH. MD. | |
| 24. FUNERAL DIRECTOR W. J. Klement, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR FEB 1 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 3, and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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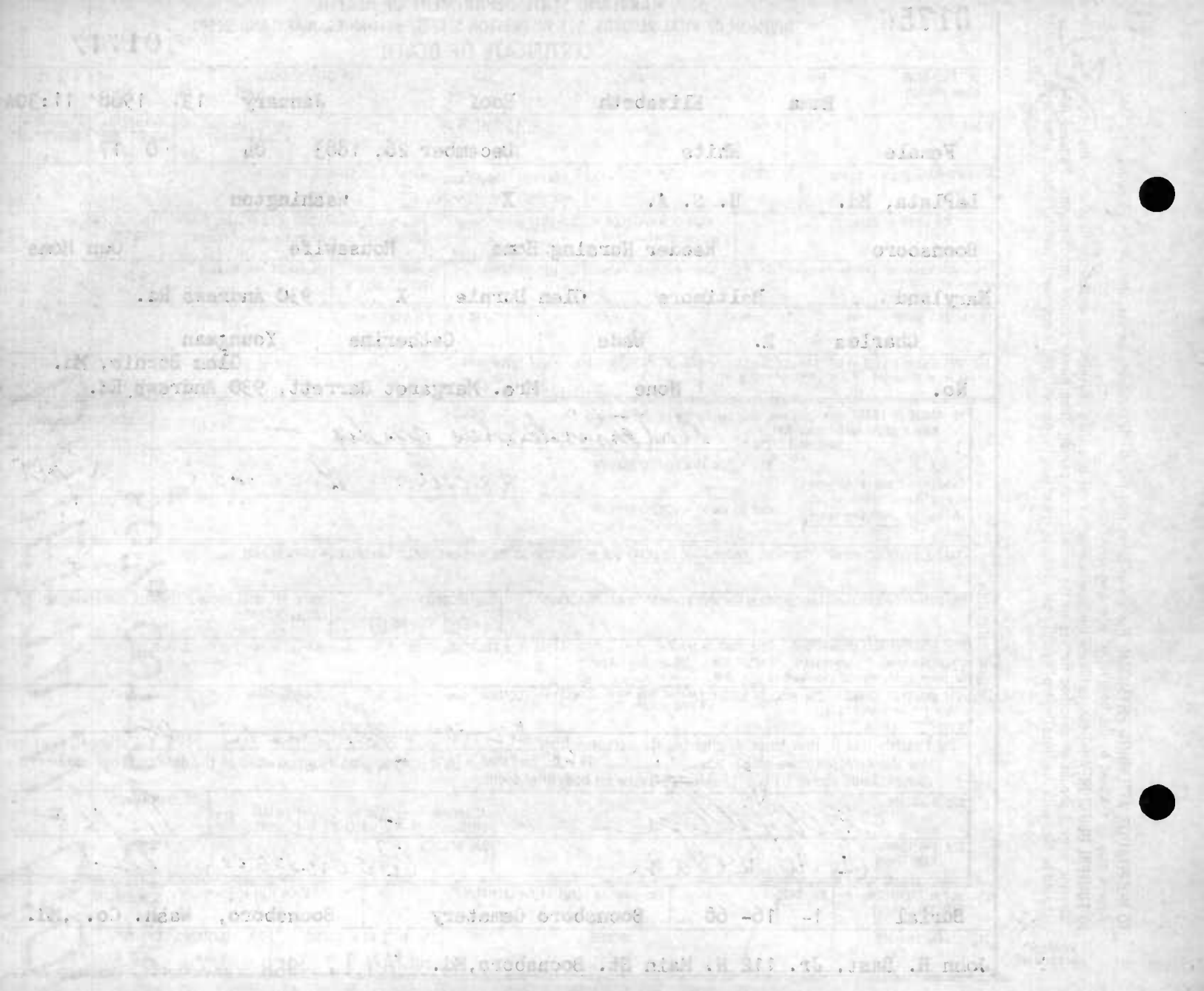
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 01747 | | | |
|---|--|---|----------------------------|---|---|---|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | First Emma | Middle Elizabeth | Lost Roof | 2a. DATE OF DEATH Month January Day 13 Year 1968 | | | 2b. HOUR 11:30A | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH December 26, 1883 | | 6. AGE (In years lost birthday) 84 YRS. | | IF UNDER 1 YEAR MONTHS 0 DAYS 17 | | IF UNDER 24 HRS. HOURS 0 MIN. 17 | |
| 7a. BIRTHPLACE (State or foreign country) LaPlata, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Boonsboro | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Reeder Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Baltimore | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 930 Andrews Rd. | | | |
| 14. FATHER'S NAME First Charles Middle E. Lost Wade | | 15. MOTHER'S MAIDEN NAME First Catherine Middle Youngman Lost | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No. (If yes give war or dates of service) | | | | | | | |
| 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Glen Burnie, Md. Mrs. Margaret Garrett, 930 Andrews Rd. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intermittent cardiac 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) 59m | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb 10 , 19 67 , to Jan 13 , 19 68 , that (I) (we) lost saw the deceased alive on Jan 11 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE G W Leman | | DEGREE D W Leman | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/15/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) D W Leman | | 22e. ADDRESS Boonsboro, Md | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1- 16- 68 | | 23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md | | | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE: JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE J. L. Leman, Jr. | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

| | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|---|---|--|------------------------|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Baby boy Rubeck | | | 2a. DATE OF DEATH Month Day Year Jan. 25 1968 | | | 2b. HOUR 12 noon | | | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Jan. 24, 1968 | | 6. AGE (In years last birthday) YRS. 1 | | IF UNDER 1 YEAR MONTHS DAYS 1 | | IF UNDER 24 HRS. HOURS MIN. 1 | | | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington County Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hos. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY X | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13e. STREET AND NUMBER | |
| 14. FATHER'S NAME First Middle Last Guy E. Rubeck | | | 15. MOTHER'S MAIDEN NAME First Middle Last Evelyn Darlene Carpenter | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> | | | 16b. SOCIAL SECURITY NO. <input checked="" type="checkbox"/> | | 17. INFORMANT Address Mrs James Rubeck Clear Spring, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hyaline Membrane Disease 776.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 773.5 (b) Prematurity DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours ?? | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Pectus Excavatum | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION None | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (we) attended the deceased from January 24, 1968 , to January 25, 1968 , that (I) (we) saw the deceased alive on Jan. 25, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Archie Robert Cohen M.D. | | | | DEGREE M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 01/27/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D. | | | | 22e. ADDRESS Clear Spring, Maryland 21722 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery | | | 23d. LOCATION (City or Town) (County) (State) Washington County Md. | | | | | | |
| 24. FUNERAL DIRECTOR Margaret Rowland | | | | ADDRESS Clear Spring, Md. | | 25a. REC'D BY REGISTRAR JAN 30 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP-

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|---|---------------------------------|--|---|--|---|--------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First Golden | Middle Mae Dawson | Last Seal | 2a. DATE OF DEATH Jan. Month 1 Day 1968 Year | | | 2b. HOUR M | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH April 22, 1910 | | 6. AGE (In years last birthday) 57 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) County, Md. Washington, | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 37 Madison Ave. | | | 12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) Housekeeper | | | 12b. KIND OF BUSINESS OR INDUSTRY Hospital | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 37 Madison Ave. | | |
| 14. FATHER'S NAME First Middle Last Harry B Seal | | | 15. MOTHER'S MAIDEN NAME First Middle Last Nora Agnes Davis | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No | | | | | |
| 16b. SOCIAL SECURITY NO. 212-24-3331 | | | 17. INFORMANT Address Md. Mrs. June L. Stahl 432 Indiana Ave. Hagerstown, | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio sclerosis, generalized + Diabetes</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>12 mos.</u> <u>20 yrs</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u> <u>4201</u> <u>4201</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-15-1962, to 1/1/1968, that (I) (we) lost saw the deceased alive on 12-11-1962, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edward W. Ditto, III, M.D. | | | | | | DEGREE MED. DIRECTOR | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/68 | |
| 22d. PHYSICIAN'S NAME (Type) Edward W. Ditto, III, M.D. | | | | | | 22e. ADDRESS 217 W. Washington St., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/4/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Washington Md. | | | | | |
| 24. FUNERAL DIRECTOR Rest Haven Funeral Chapel Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR JAN 4 1968 | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | | | |

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | | |
| PAUL | | | FRANKLIN | | | SHOWE | | JANUARY 19 1968 6:20AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | |
| MALE | | WHITE | | JANUARY 19, 1968 | | 7 HR. 10 MIN. | | 7 5 | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| MARYLAND | | UNITED STATES | | | | WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| HAGERSTOWN | | | WASHINGTON COUNTY HOSPITAL | | | NONE | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MARYLAND | | | WASHINGTON | | HAGERSTOWN | | | | 742 MEDWAY ROAD | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| HARRY MELVIN SHOWE | | | BARBARA ANN DIFABIO | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | NONE | | "MOTHER" | | 742 MEDWAY ROAD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PREMATURE SEPARATION OF PLACENTA</u> <u>7701</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>7610</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 MIN.</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>VAGINAL BLEEDING APPROX 2 WK. (MOTHER)</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-19</u> , 19 <u>68</u> , to <u>1-20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>1-19</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Robert V.L. Campbell</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/21/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>ROBERT VL CAMPBELL</u> | | | | 22e. ADDRESS <u>HAGERSTOWN, MARYLAND</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE <u>1-22-68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Wash. Co. Md</u> | | | | |
| 24. FUNERAL DIRECTOR <u>ANDREW K. COFFMAN Funeral Home Inc</u> | | | | ADDRESS <u>Hagerstown Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 23 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | c. LENGTH OF STAY IN 1b LIFE | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | d. STREET ADDRESS 727 SUMMIT AVE. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First MADELINE Middle VIRGINIA Last SHUPP | | 4. DATE OF DEATH Month JANUARY Day 14 Year 1968 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/8/1920 |
| 9. AGE (In years lost birthday) yrs. 47 | | IF UNDER 1 YEAR Months 1 Days 14 Hours 14 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK | | 10b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME AMOS M. ALGER | | 14. MOTHER'S MAIDEN NAME ELIZABETH HART | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 213-18-9269 | |
| 17. INFORMANT MR. E. RUSSELL SHUPP JR. | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma - Generalized. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 2001 | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct 16 , 1965, to Jan 14 , 1968, that (I) (we) last saw the deceased alive on Jan 14 , 1968, and that death occurred at 10 A. M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE Lloyd A. Hoffman | | 22b. DATE SIGNED 1/15/68 | |
| 22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman | | 22d. ADDRESS 214 N. Pot-st. Hagerstown, Md | |
| 23a. BURIAL, CREMATION, or other disposition (Type) BURIAL | 23b. DATE THEREOF 1/16/68 | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | 23d. LOCATION (City or Town) (County) (State) CLEARSPRING WASH. MD. |
| 24. FUNERAL DIRECTOR W. J. Hornum, Hagerstown, Md | | 25a. REC'D BY REGISTRAR JAN 18 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|---|---|---------------------------------------|--|---|--|---|--|--|
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| 01752 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) James Heflebower Smith | | | | | | 2a. DATE OF DEATH Month January Day 6 , Year 1968 | | | 2b. HOUR 10:30 AM | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH July 15, 1891 | | 6. AGE (In years last birthday) 76 YRS. | | IF UNDER 1 YEAR MONTHS 5 DAYS 21 | | IF UNDER 24 HRS. HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) Pleasant Valley Md | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Civil Engineer | | | 12b. KIND OF BUSINESS OR INDUSTRY Engineering | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Knoxville | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER P. O. Box 229 | | |
| 14. FATHER'S NAME First Middle Last James Smith | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Cecilia Thomas | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) Yes | | (If yes give war or dates of service) W. W. One | | 16b. SOCIAL SECURITY NO. 219-20-2585 | | 17. INFORMANT Address Mrs. Eleanora B. Smith. Box 229 Knoxville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolus 410.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) acute myocardial infarct DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerosis - heart failure | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 Hours 20 Days Years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Compartment heart failure | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-28 , 19 61 , to 1-6 , 19 68 , that (I) (we) last saw the deceased alive on 1-6-68 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Joseph Secordari | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 1-8-1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) JOSEPH SECORDARI | | | | | | 22e. ADDRESS Boonsboro Md | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER (Specify) Burial | | 23b. DATE 1-10-68 | | 23c. NAME OF CEMETERY OR CREMATORY Rohrersville Cemetery | | 23d. LOCATION (City or Town) (County) (State) Rohrersville, Wash. Md. | | | | | |
| 24. FUNERAL DIRECTOR ADDRESS John H. Bast, Jr. 112 N. Main St. Boonsboro, Md | | | | | | 25a. REGD. BY REGISTRAR JAN 12 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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Washington County Hospital Washington County Hospital Washington County Hospital Washington County Hospital Washington County Hospital

Memphis Memphis Memphis Memphis Memphis

James Hoffbauer James Hoffbauer James Hoffbauer James Hoffbauer James Hoffbauer

Box 122 Knoxville Box 122 Knoxville Box 122 Knoxville Box 122 Knoxville Box 122 Knoxville

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|--|---|--|---|-----------------------------------|----------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01762 | | | | | 01753 | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR |
| First Middle Last RALPH LYNWOOD SMITH | | | | | Month Day Year Jany 3 1968 | | | | 5.30 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | |
| Male | | white | | Sept 18 1917 | | 50 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Hagerstown | | USA | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | Wash County Hospital | | | Shoe Repair | | | -- | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. CITY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Hagerstown | | | | 635 W. Washington St | |
| 14. FATHER'S NAME First Middle Last | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | |
| George H. Smith | | | | | Carrie May Knox | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT Address | | | | | |
| No | | 213-12-7804 | | Mrs Grace A. Smith 635 W. Washington St | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Delirium tremens & Acute pulmonary edema | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Chronic edema & congestion of brain | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Chronic alcoholism | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 307 X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes. | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30, 1967, to 1/3, 1968, that (I) (we) last saw the deceased alive on 1/3, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| George Jennings MD | | 1/5/68 | | George Jennings | | | | | |
| 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | | | | | | | |
| 318 N. Patomac St Hagerstown, Md. | | Andrew K. Coffman | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/6/68 | | Rose Hill Cemetery | | Hagerstown Wash Co Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Hagerstown Md. | | | | | DATE JAN 9 1968 | | Charles Judge | | |

01712

01712

RECORD OF DEATH

DATE

PLACE

AGE

1917

1917

1917

1917

1917

1917

Chronic disease of heart
Chronic disease of heart
Chronic disease of heart

1917

1917

George Jennings
George Jennings

George Jennings
George Jennings

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

BP-

VR 115 (4)
30M REV. 1/68

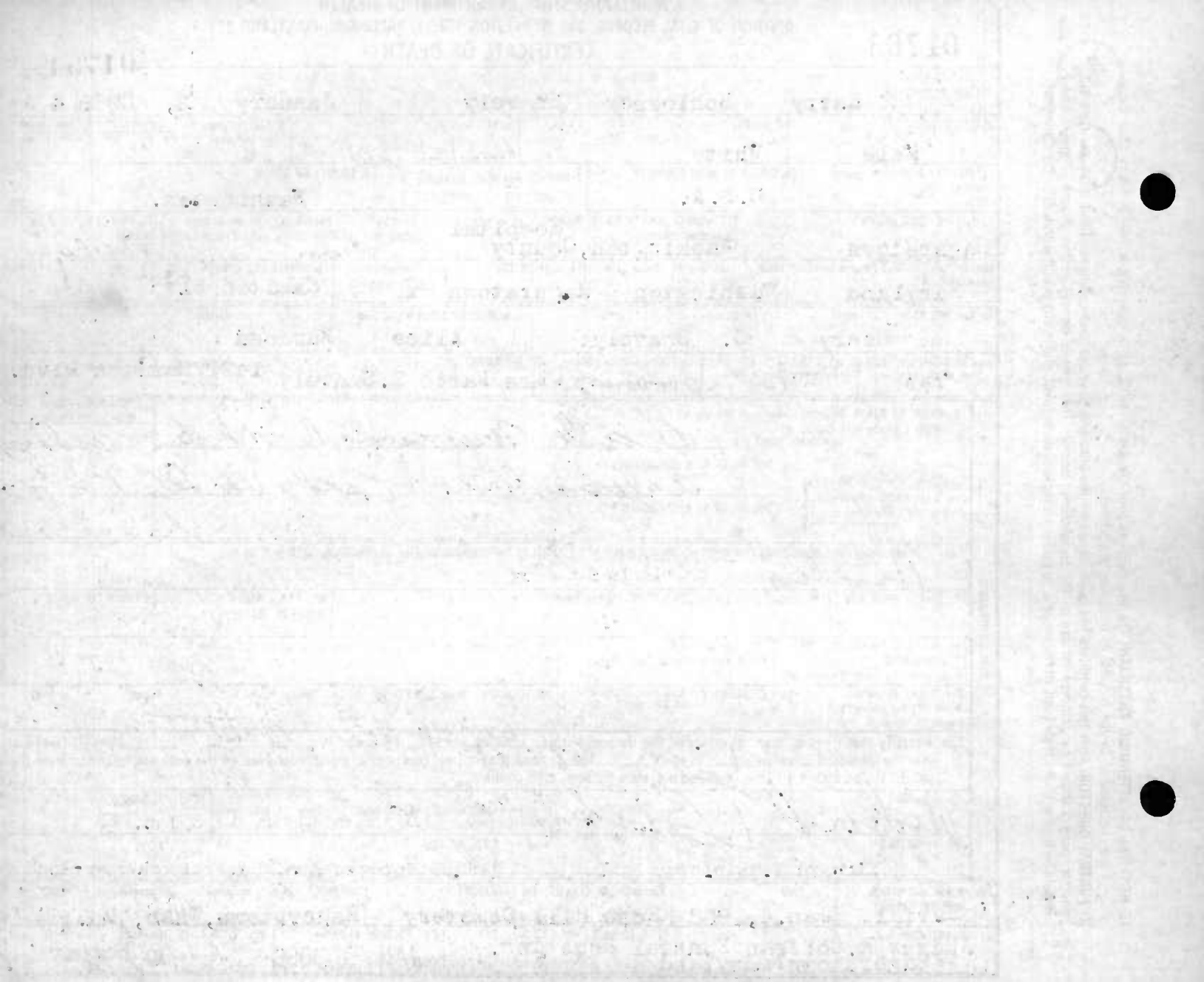
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

01763

CERTIFICATE OF DEATH

01754

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME (Type or print) First Middle Last Harry Schlosser Snavelly | | | 2a. DATE OF DEATH Month Day Year January 2, 1968 | | | 2b. HOUR 4 A M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH April 26, 1894 | | 6. AGE (In years last birthday) 73 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington. Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Hospital Washington, County | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Salesman | | 12b. KIND OF BUSINESS OR INDUSTRY Deputy | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 1431 Hamiton Blvd | |
| 14. FATHER'S NAME First Middle Last Henry S. Snavelly | | | 15. MOTHER'S MAIDEN NAME First Middle Last Alice Hammond | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown (If yes give branch of service) Yes WW#2 | | 16b. SOCIAL SECURITY NO. 214-09-0583 | | 17. INFORMANT Mrs Marie S. Snavelly | | Address 1431 Hamiton Blvd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Arteriosclerotic Cardio Vasc. Dis. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days, 1-2 yr | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Healed Hernia | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital), attended the deceased from April 1963 , to Date , 19____, that (I) (we) last saw the deceased alive on Jan 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did/did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Richard T. Binford, M.D. | | | | 22c. DATE SIGNED 3 Jan. 68 | | 22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D. | | 22e. ADDRESS 1135 Potomac Ave. Hagerstown, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE Jan. 4, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Wash. Md. | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Maryland | | | | 25a. REC'D BY REGISTRAR DATE JAN 8 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|-------------------------|---|---|---|---|
| 01764 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01755 | |
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last ALBERT ROY SPRECHER | | | 2a. DATE OF DEATH Month Day Year Jan 5 1968 | | 2b. HOUR 7P M |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH Oct 17 1881 | | 6. AGE (In years last birthday) 86 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) Wash Co Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. COUNTY OF DEATH Washington | | Md. | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown RFD | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Avalon Manor | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bank Cashier | |
| 12b. KIND OF BUSINESS OR INDUSTRY Retired | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland | | 13b. CITY OR TOWN Washington Hagerstown | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13d. STREET AND NUMBER Huyetts Gross Rds | | | | | |
| 14. FATHER'S NAME First Middle Last Daniel Sprecher | | | 15. MOTHER'S MAIDEN NAME First Middle Last Martha A Miller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 214-34-0898 | | 17. INFORMANT Address R # Grover M. Sprecher Hagerstown Md R # 3 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial pneumonia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 485X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis severe, Senile psychosis | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 1964 , to Jan. 5, 1968 , and that (I) (we) last saw the deceased alive on Jan. 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Omar D. Sprecher, Jr. M.D. | | DEGREE DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) Omar D. Sprecher, Jr. | | 22e. ADDRESS 1229 Ravenwood Heights Hagerstown, Md. | | 22c. DATE SIGNED 1/8/68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/9/68 | | 23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery | |
| 23d. LOCATION (City or Town) (County) (State) Broadfording Wash Co Md | | | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman | | Hagerstown Md. ADDRESS Funeral Home Inc | | 25a. REC'D BY REGISTRAR JAN 9 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

01715

OFFICE OF CLERK

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General of 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01765 | | | | | 01756 | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | c. LENGTH OF STAY IN lb 30 YRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 334 JEFFERSON ST. | | | | | d. STREET ADDRESS 334 JEFFERSON ST. | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH STEVENS | | | | | 4. DATE OF DEATH Month Day Year JANUARY 9 1968 | | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 4/5/1888 | | 9. AGE (In years last birthday) yrs. 79 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | |
| 13. FATHER'S NAME ARCHIBALD McCALLISTER | | | | | 14. MOTHER'S MAIDEN NAME EMMA SUFFACOO | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | | 16. SOCIAL SECURITY NO. 217-10-2838A | | 17. INFORMANT MR. THEODORE STEVENS | | | Address HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular fibrillation DUE TO Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4200 (b) Indef. (c) Indef. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH Indef. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma, bladder, transitional cell | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-11 , 19 64 , to death , that (I) (we) last saw the deceased alive on 1-1 , 19 68 , and that death occurred at 10:30 AM , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE Robert F. Keedle | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1-10-68 | | | |
| 22c. PHYSICIAN'S NAME (Type) Robert F. Keedle | | | | 22d. ADDRESS Hagerstown Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 1/11/68 | | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM. | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. | | |
| 24. FUNERAL DIRECTOR W. J. Normant Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|-----------------------------------|------------------------|---|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 01766 | | | | | | | | | | | |
| 01757 | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR | | |
| Margaret | | | Armstrong | Stewart | January 17 1968 | | | 1 P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS | | | |
| Female | | White | | March 25, 1898 | | 69 YRS. | | IF UNDER 24 HRS. HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Gettysburg, Pa. | | USA | | | | Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | 29 Roessner Ave. | | | Teacher | | Public School | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Hagerstown | | YES | | 29 Roessner Ave. | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Henry | | | A | Stewart | Jennie | Armstrong | | | Battin | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | | | |
| No | | | 147-30-6788A | | | D.M. Stewart 29 Roessner Ave. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>years</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan.</u> , 19 <u>62</u> , to <u>Jan.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>November 29</u> , 19 <u>67</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | 22c. DATE SIGNED | | | 22d. PHYSICIAN'S NAME (Type) | | | | | |
| <u>Howard N. Weeks</u> | | | 1/20/68 | | | Howard N. Weeks, M.D. | | | | | |
| 22e. ADDRESS | | | 22f. ADDRESS | | | | | | | | |
| 580 Northern Avenue | | | 580 Northern Avenue | | | | | | | | |
| Hagerstown, Maryland | | | Hagerstown, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1/20/68 | | Rest Haven Cemetery | | | Hagerstown Washington Md. | | | | |
| 24. FUNERAL DIRECTOR | | 24b. ADDRESS | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Wm. C. Horst | | Hagerstown, Md. | | JAN 23 1968 | | | [Signature] | | | | |

0845

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

1-588

OFFICE OF THE ATTORNEY GENERAL

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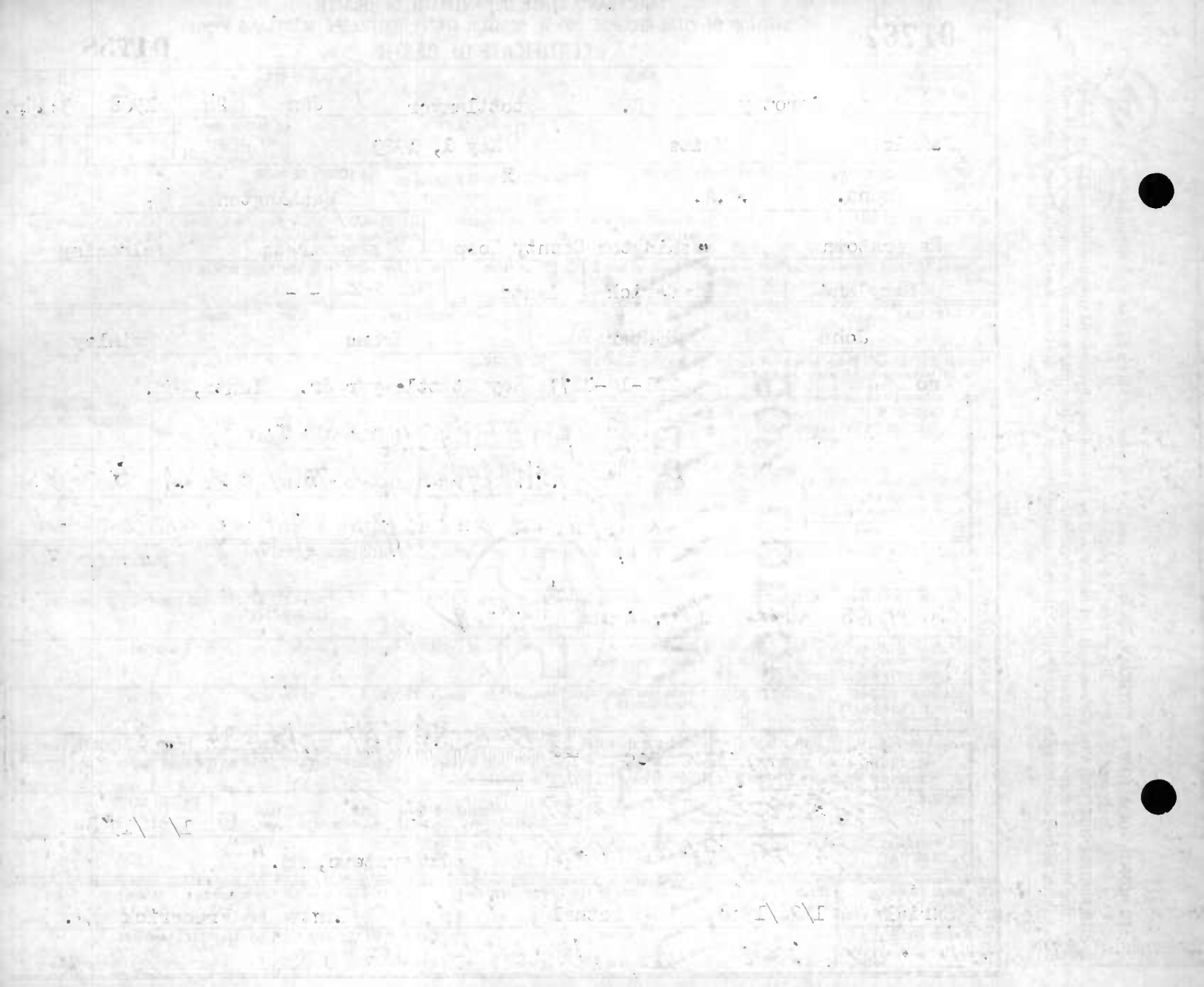
208 COLUMBIA UNIVERSITY
1-588

Wm. C. C. C. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|------------------------------|--|---|------------------------------------|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR |
| Dorothy | | | R. | Stottlemeyer | Jan | 24 | 1968 | 3:15p | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| Female | | White | | May 1, 1923 | | 44 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Penna. | | U.S.A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Washington County Hosp | | | seamstress | | clothing | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Frederick | | Lantz | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | -- |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| John | | | Dunbar | | | Irene | | | Hainley |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address |
| no | | | 201-16-0677 | | Roy Stottlemeyer Jr. | | | | Lantz, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Post-craniotomy cerebral edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Ruptured aneurysm right and left internal carotid</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carotid</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 430.9 | | | | | | | | | 5 days |
| 330x | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| Jan. 19, 68 | | | Ruptured intracranial aneurysm | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec. 26, 1967</u> to <u>Jan. 24, 1968</u> , that (I) (we) lost saw the deceased alive on <u>Jan. 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>A. F. Abdullah M.D.</u> | | | | | | 22c. DATE SIGNED 1/25/1968 | | | |
| 22d. PHYSICIAN'S NAME (Type) <u>A. F. Abdullah</u> | | | | | | 22e. ADDRESS Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 1/26/1968 | | Bethel | | Lantz Frederick Md. | | |
| 24. FUNERAL DIRECTOR <u>Walter Y. Grove</u> | | | | | | ADDRESS <u>Waynesboro Pa</u> | | 25a. REC'D BY REGISTRAR DATE <u>JAN 29 1968</u> | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 01768 CERTIFICATE OF DEATH 01759 | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Lost | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| George Edward Teach | | | | | | Jan. Month 3 Day Year 1968 | | | 4:30 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | White | | July 16, 1903 | | 64 YRS. | | 5 17 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Wash. Co. Md. | | U.S.A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown Md. | | | Wash. Co. Hospital | | | Car Operator | | | Brick Yard |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Washington | | Pinesburg | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Williamsport RFD #2 |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Lost Jacob Teach | | | First Middle Lost Emma Smith | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| | | | 220-09-9241 | | Mrs. Anna Teach Pinesburg Williamsport, Md. RFD #2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>none</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 mos? | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 157X | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | Obstructive Jaundice | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | 4:30 P.M. Month 1 Day 3 Year 1968 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-23, 1960, to 1-3, 1968, that (I) (we) last saw the deceased alive on 1-3-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED | |
| M.E. Byrkit M.D. | | | | | | | | 1-4-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| M.E. Byrkit M.D. | | 28 West Potomac St. Williamsport, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REINTERMENT (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Jan. 6, 1968 | | Greenlawn Cemetery | | Williamsport, Washington, Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Albert L. Leaf Williamsport, Md. | | | | | JAN 8 1968 | | Charles Judge | | |

23710

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01769

01760

| | | | | | | | | | | | |
|--|--|--|---|---|------|---|--|---|--------------------|--------------------------------|--|
| 1. DECEASED-NAME (Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR 11 A M | | |
| RAYMOND RUDOLPH TEWALT | | | | | | Jany 10 1968 | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH Nov 23 1907 | | 6. AGE (In years last birthday) 60 YRS. | | 7. UNDER 1 YEAR MONTHS DAYS | | 8. UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Middletown Va | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 735 Potomac Ave | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Teacher | | 12b. KIND OF BUSINESS OR INDUSTRY School | | | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 826 Washington Ave | | | |
| 14. FATHER'S NAME First Middle Last John H. Tewalt | | | 15. MOTHER'S MAIDEN NAME First Middle Last Edith Ault | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No | | 16b. SOCIAL SECURITY NO. -- | | 17. INFORMANT Mrs Ruth B. Tewalt | | Address 826 Wash Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1 year</u> | | | | | | Hagerstown Md. Instant | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Dec. 20, 1967, to Jan. 10, 1968, that (I) (we) last saw the deceased alive on Dec. 31, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | 22c. DATE SIGNED 1-11-68 | | 22d. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr. | | | | | | | |
| 22e. ADDRESS 215 W. Washington St., Hagerstown, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1/13/68 | | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md | | | | | |
| 24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc | | 25a. REC'D BY REGISTRAR DATE JAN 15 1968 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |

01710

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RECEIVED

NOV 22 1967

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

WASHINGTON, D.C. 20535

TO : DIRECTOR, FBI

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [REDACTED]

RE: [REDACTED]

On 11/21/67, [REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MEDICAL CERTIFICATION

| 1. DECEASED-NAME (Type or print) | | | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
|---|--|--|--|--|--|---|--|--|--|--|--|---|--|----------------------------|--|
| VERNON BAUGHMAN THOMAS | | | | | | | | | | Jan. 15 1968 | | | | 10A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| Male | | White | | January 23, 1905 | | | | 62 YRS. | | MONTHS DAYS | | HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | | Md. | | | |
| Maryland | | U.S.A. | | | | Washington | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | | Washington Cty. Hosp. | | | | Painter | | | | Fairchild | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | | | | |
| Maryland | | | | Washington | | Hagerstown | | | | 517 Indiana Ave | | | | | |
| 14. FATHER'S NAME | | | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | | | First Middle Last | |
| Tillson | | | | | | | | Thomas | | Mary | | | | Matthews | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address | | | | | |
| yes | | | | W.W. #2 | | Mrs. Ruth E. Thomas | | | | 517 Indiana Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 197.8 Carcinoma Of Liver | | | | | | | | | | 3 months | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | | | | | |
| 1561 | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1968, to Jan. 15, 1968, that (I) (we) last saw the deceased alive on Jan. 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| Dr. E. W. Ditto, Jr. | | | | | | | | | | | | | | 1-16-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | |
| 215 W. Washington St., Hagerstown, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | 1/18/68 | | Rose Hill Cemetery | | | | Hagerstown, Wash. Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| A.K. Coffman Funeral Home, Hagerstown, Md. | | | | | | | | | | | | JAN 19 1968 | | Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|--|--|--|---|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First BESSIE | | Middle VIOLA | | Last THUM | | 2a. DATE OF DEATH Month 1 / Day 19 / Year 68 | | |
| 3. SEX FEMALE | | | 4. RACE WHITE | | 5. DATE OF BIRTH FEBRUARY 9, 1884 | | | 6. AGE (In years last birthday) 83 YRS. | | 2b. HOUR 2:15 A | |
| 7a. BIRTHPLACE (State or foreign country) PENNSYLVANIA | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WASHINGTON CO. HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY OWN HOME | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | | 13b. COUNTY WASHINGTON | | 13c. CITY OR TOWN HAGERSTOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 27 EAST WASHINGTON STREET | | |
| 14. FATHER'S NAME First BENJAMIN | | | Middle F. | | Last DUKE | | 15. MOTHER'S MAIDEN NAME First MARGARET | | | Middle E. Last BOLES | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) NO | | | 16b. SOCIAL SECURITY NO. 220-09-9168A | | 17. INFORMANT 612 GUILFORD AVENUE, HAGERSTOWN, MARYLAND. MRS. JULIA F. SCHMIDT | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours 1 yr, 8 months | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertensive cardiovascular disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from January 2, 1968 , to Jan. 19, 1968 , that (I) (we) last saw the deceased alive on January 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>W. T. Layman</i> | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED 1/19/68 | | |
| 22d. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN, M.D. | | | | | | 22e. ADDRESS PROF. ARTS BLDG. PUBLIC SQ. HAGERSTOWN, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | | 23b. DATE 1/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY | | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD. | | | |
| 24. FUNERAL DIRECTOR <i>Charles R. Rouser</i> | | | | | | 25a. REC'D BY REGISTRAR JAN 24 1968 | | | 25b. REGISTRAR'S SIGNATURE <i>Charles R. Rouser</i> | | |

01585

RECEIVED IN DEPT

01585

TO THE SECRETARY OF THE DEPARTMENT OF THE ARMY

FROM THE SECRETARY OF THE DEPARTMENT OF THE ARMY

SUBJECT: [Illegible]

DATE: [Illegible]

REFERENCE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

01772

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01763

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | |
| b. CITY OR TOWN (If outside corporate limits, write town) HAGERSTOWN | | c. LENGTH OF STAY in 1b LIFE | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN | | d. STREET ADDRESS RT. #5 HAGERSTOWN | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL | | e. IS RESIDENCE ON A FARM? X YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) IVA First LOUISE Middle TURNER Last | | 4. DATE OF DEATH JANUARY 14 1968 Month Day Year | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/31/1913 |
| 9. AGE (In years last birthday) 54 yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during 10 days immediately preceding death, if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY U.S.A. | |
| 13. FATHER'S NAME BENJAMIN F. STOUFFER | | 14. MOTHER'S MAIDEN NAME MARY ELLEN SMITH | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. 214-09-0629 | |
| 17. INFORMANT MR. CHARLES T. TURNER | | RT. #5 HAGERSTOWN MD. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Coronary Artery Thrombosis 4109 DUE TO (b) Coronary artery sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 1 Hour unknown | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201 | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from August 1967 , to 1/15 1968 , that (I) (we) saw the deceased alive on 1/8 1968 , and that death occurred at 12:05 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE George Jennings | | 22b. DATE SIGNED 1/16/68 | |
| 22c. PHYSICIAN'S NAME (Type) George Jennings | | 22d. ADDRESS 318 N. Potomac St. Hagerstown, Md. | |
| 23a. BURIAL CREMATION, REMOVAL (Type) BURIAL | 23b. DATE THEREOF 1/17/68 | 23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM. | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. |
| 24. FUNERAL DIRECTOR W. J. Normant, Hagerstown, Md. | | 25a. REC'D BY REGISTRAR JAN 19 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01773

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01764

| | | | | | |
|--|--|---|--|--|--|
| 1. DECEASED-NAME (Type or print) Carrie Elizabeth Weaver | | | 2a. DATE OF DEATH Month January Day 25 Year 1968 | | 2b. HOUR 1:22 ^A _M |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH May 5, 1890 | | 6. AGE (In years last birthday) 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) York, Pa. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Washington | 13c. CITY OR TOWN Hagerstown | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 330 Bryan Place | |
| 14. FATHER'S NAME First John Middle Michael Last Rexroth | | 15. MOTHER'S MAIDEN NAME First Lydia Middle Ann Last Akins | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT Address Mr. E.G. Weaver 330 Bryan Pl. Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis left middle cerebral artery 433.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 X (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 wks. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertensive cardiovascular disease, arteriosclerotic | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1968 , to Jan. 25, 1968 , that (I) (we) last saw the deceased alive on Jan. 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE B. B. Kneisley | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 1/26/68 | |
| 22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D. | | | 22e. ADDRESS 148 West Washington Street Hagerstown, Maryland | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1/27/68 | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State) Hagerstown Washington Md | |
| 24. FUNERAL DIRECTOR Wm. G. Horst | | ADDRESS Rest Haven Funeral Chapel Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 29 1968 | 25b. REGISTRAR'S SIGNATURE Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

01774

01765

| | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|--|--|--|--|---|--|--|
| 1. DECEASED-NAME (Type or print) Dora | | | First Bell | | | Middle Weber | | | Last Weber | | | 2a. DATE OF DEATH Month January Day 9 Year 1968 | | | 2b. HOUR 3:50 PM | | |
| 3. SEX Female | | | 4. RACE White | | | 5. DATE OF BIRTH 10/5/04 | | | 6. AGE (In years last birthday) 63 YRS. | | | IF UNDER 1 YEAR MONTHS 63 DAYS 63 HOURS 63 MIN. | | | IF UNDER 24 HRS. HOURS 63 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) West Virginia | | | 7b. CITIZEN OF WHAT COUNTRY? United States | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH WASHINGTON | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | | 13c. CITY OR TOWN Clear Spring | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER Route 2 | | | | | |
| 14. FATHER'S NAME Thomas | | | First Householder | | | Middle Rose | | | Last A. McBee | | | 15. MOTHER'S MAIDEN NAME Rose | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | | 17. INFORMANT Anna Rowland | | | Address Clear Spring, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acoustic Neuroma 2389 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 11 yrs. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 237X | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from Nov. 9 , 19 60 , to Jan. 9 , 19 68 , that (I) (we) last saw the deceased alive on Jan. 9 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Fe U. Porciuncula M.D. | | | 22c. DATE SIGNED 1/9/68 | | | 22d. PHYSICIAN'S NAME (Type) Fe U. Porciuncula | | | 22e. ADDRESS Western Maryland State Hospital 1500 Pennsylvania Ave., Hagerstown, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | 23b. DATE 1-13-68 | | | 23c. NAME OF CEMETERY OR CREMATORY Highland | | | 23d. LOCATION (City or Town) (County) (State) Morgan Co., W. Va | | | | | | | | |
| 24. FUNERAL DIRECTOR Thomas H. Hunter | | | 24a. REC'D BY REGISTRAR BERKELEY SPRINGS, W.V. | | | 24b. REGISTRAR'S SIGNATURE Charles J. [Signature] | | | | | | | | | | | |

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 01766 | |
|--|---------|--|--|--|------|---|------|---|---|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| DOLLIE ANN WELLS | | | | | | Month Day Year | | | 1-1-1968 Noon | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Female | Negro | Aug. 18, 1880 | 87 YRS. | MONTHS | DAYS | HOURS | MIN. | Month Day Year | 1-1-1968 | P. M. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | 9. COUNTY OF DEATH | | | | | |
| Virginia | | U.S.A. | | WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Washington | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | | | | Housewife | | | Home | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | | 13d. INSIDE CITY LIMITS? | | |
| Maryland | | | Washington | | | Hagerstown | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 13e. STREET AND NUMBER | | | | | |
| First Middle Last | | | First Middle Last | | | 159 N. Jonathan Street | | | | | |
| Thomas Clay | | | Mary Carter | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | ADDRESS | | |
| No | | | None | | | Mrs. Alexander Kelley | | | 174 E. Liberty St. Chambersburg, Pa. 17201 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Malnutrition</u> | | | | | | | | | | 2 years | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | 5 years | |
| (b) <u>Arteriosclerotic Heart Disease</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 4200 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER | | | 1-2-68 | | | | | |
| Dr. E. W. Ditto, Jr. | | | 22c. NAME OF CEMETERY OR CREMATORY | | | 22d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | | Lebanon Cemetery Chambersburg Franklin, Pa. | | | | | | | | |
| 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| 1/5/68 | | | Lebanon Cemetery Chambersburg Franklin, Pa. | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| John O. Park | | | DATE JAN 8 1968 | | | Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01776

01767

| | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| 1. DECEASED-NAME (Type or print) EVELYN Louise Wesley | | | 2a. DATE OF DEATH Jan Month 17 Day 68 Year | | | 2b. HOUR 7:25 PM | | | |
| 3. SEX FEMALE | | 4. RACE COLORED | | 5. DATE OF BIRTH DEC. 26, 1900 | | 6. AGE (In years last birthday) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) MD. CARROLL Co. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSE WIFE | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND | | 13b. COUNTY CARROLL | | 13c. CITY OR TOWN WESTMINSTER | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 6 UNION ST. | |
| 14. FATHER'S NAME First Middle Last ANTHONY A. JACKSON | | | 15. MOTHER'S MAIDEN NAME First Middle Last CORA BLACK | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) NO (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. 051-14-4114 | | 17. INFORMANT MRS. EDNA M. BURROWS Address 6 UNION ST. WESTMINSTER, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 481x DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 470x (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-16, 1966 , to 1-17, 1968 , that (I) (we) last saw the deceased alive on 1-17, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Edwin G. Riley DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | | 22c. DATE SIGNED 1-18-68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Edwin G. Riley | | | | | | 22e. ADDRESS 1500 Pennsylvania 12, Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE 1/22/68 | | 23c. NAME OF CEMETERY OR CREMATORY WESTERN CHAPEL CEMETERY | | 23d. LOCATION (City or Town) (County) (State) NEW WINDSOR, R.D. MD. | | | |
| 24. FUNERAL DIRECTOR J. S. Myers & Co., Westminster, Md. | | | | 25a. REC'D BY REGISTRAR DATE JAN 22 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

MEDICAL CERTIFICATION

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ANTHONY A. JACKSON, CORP. 18409

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William D. Green
Edward F. Riley

Edwin G. Riley

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|---|-------------------------|---|---|--|---|
| 01777 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 01768 | |
| Item #3 Film G 423 4/15/70 jb | | | | | |
| CERTIFICATE OF DEATH | | | | | |
| 1. DECEASED-NAME (Type or print) Raymond A. Willard | | | 2a. DATE OF DEATH Month Jan. Day 2 Year 1968 | | 2b. HOUR 11:45 M |
| 3. SEX Male | 4. RACE White | | 5. DATE OF BIRTH Sept. 5, 1905 | | 6. AGE (In years last birthday) 62 YRS. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Wash Co. |
| 10. CITY OR TOWN OF DEATH Smithsburg RD 1 | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Own Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Smithsburg | |
| 14. FATHER'S NAME William A. Willard | | 15. MOTHER'S MAIDEN NAME Anna Hauver | | 12b. KIND OF BUSINESS OR INDUSTRY Own Farm | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? No | | 16b. SOCIAL SECURITY NO. 194-26-6973 | | 17. INFORMANT Mrs. Vera Willard | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1541 IMMEDIATE CAUSE (a) Carcinoma of rectum & lower bowel DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 154X | | | | | |
| 19a. DATE OF OPERATION Sept 15-67 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Relief of tumor obstruction | | 20a. AUTOPSY? NO | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY 10:00 HOUR A.M. Month Day Year 19 P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) _____ | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) _____ | | 21f. LOCATION Street or R.F.D. No. City or Town County State _____ | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1, 1967 , to Jan 2, 1968 , that (I) (we) last saw the deceased alive on Oct. 1, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE James T. Gray M.D. | | 22c. DATE SIGNED 1-3-68 | | 22d. ADDRESS Thurmont-Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 1-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY Grossnickle Ch of Bre. | |
| 23d. LOCATION (City or Town) (County) (State) Thurmont, Md. | | 23e. REC'D BY REGISTRAR JAN 8 1968 | | 23f. REGISTRAR'S SIGNATURE Charles J. ... | |
| 24. FUNERAL DIRECTOR Raymond E. Creager | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01778

01769

| | | | | | |
|--|--|---|---|--|--|
| 1. DECEASED-NAME (Type or print) David Ralph Williams | | | 2a. DATE OF DEATH Month 1 Day 19 Year 68 | | 2b. HOUR 11:35A |
| 3. SEX male | 4. RACE white | 5. DATE OF BIRTH 10-7-92 | | 6. AGE (In years last birthday) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) Maryland | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH Washington Md. | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Driver | 12b. KIND OF BUSINESS OR INDUSTRY Bus Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md. | 13b. COUNTY Wash. | 13c. CITY OR TOWN Funkstown | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER 14 W. Baltimore St. | |
| 14. FATHER'S NAME First David Middle K. Last Williams | | 15. MOTHER'S MAIDEN NAME First Etta Middle King | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. 214-10-4167 | 17. INFORMANT Address Mr. Donald Williams Rt2 Smithsburg, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis, acute DUE TO, OR AS A CONSEQUENCE OF generalized (b) Arteriosclerotic heart disease; arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF unknown (c) 4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4207 | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Uremia and pleural effusion | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-21-62 , 19____, to 1-19-68 , 19____, that (I) (we) last saw the deceased alive on 1-19-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <i>E. R. Lardizabal</i> | DEGREE M.D. | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22c. DATE SIGNED 1-22-68 | | |
| 22d. PHYSICIAN'S NAME (Type) E. R. Lardizabal, M. D. | 22e. ADDRESS 300 N. Potomac St. Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 1-23-68 | 23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery | 23d. LOCATION (City or Town) (County) (State) Hagerstown, Md. | | |
| 24. FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md. | | 25a. REC'D BY REGISTRAR DATE JAN 25 1968 | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | |

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

01770

| | | | | | |
|--|-------------------------|---|---|--|---|
| 1. DECEASED-NAME (Type or print) First <i>Russell</i> Middle <i>nmn</i> Last <i>Wilson</i> | | | 2a. DATE OF DEATH Month <i>January</i> Day <i>7</i> Year <i>1968</i> | | 2b. HOUR <i>12:15</i> M |
| 3. SEX <i>Male</i> | 4. RACE <i>White</i> | | 5. DATE OF BIRTH <i>February 14, 1892</i> | | 6. AGE (In years last birthday) <i>76</i> YRS. |
| 7a. BIRTHPLACE (State or foreign country) <i>W. Va.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Washington</i> Md. |
| 10. CITY OR TOWN OF DEATH <i>Hagerstown</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Restaurant</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i> | | 13b. COUNTY <i>Washington</i> | 13c. CITY OR TOWN <i>Hagerstown</i> | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER <i>Route # 3</i> |
| 14. FATHER'S NAME First <i>William</i> Middle <i>Wilson</i> Last <i>Wilson</i> | | 15. MOTHER'S MAIDEN NAME First <i>Anney</i> Middle <i>Japp</i> Last <i>Japp</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <i>No</i> | | 16b. SOCIAL SECURITY NO. <i>214-09-9511A</i> | | 17. INFORMANT Address <i>Mr. Milford Wilson R # 6 Hagerstown, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis with Right Hemiplegia & Intracerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hemiplegia & Intracerebral Hemorrhage</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Hemiplegia & Intracerebral Hemorrhage</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>332X</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Subacute Myelitis - Obstructive Exogenous</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>12-18</i> , 19 <i>53</i> , to <i>1-7-</i> , 19 <i>68</i> , that (I) (was) lost saw the deceased alive on <i>1-7-</i> , 19 <i>68</i> , and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) view the body after death. | | | | | |
| 22b. SIGNATURE <i>Dalton M. Welty, M.D.</i> | | 22c. DATE SIGNED <i>1-8-68</i> | | 22d. ADDRESS <i>998 Potomac Avenue, Hagerstown, Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE <i>1/9/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i> | |
| 24. FUNERAL DIRECTOR <i>Rest Haven Funeral Chapel</i> | | 25a. REC'D BY REGISTRAR <i>JAN 10 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

01780

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| | | | | | | | |
|---|--|---|---|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Washington MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | | c. LENGTH OF STAY IN lb 12 Days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital | | | | d. STREET ADDRESS 1424 Jefferson Blvd. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Crawford A. Wishard | | | | 4. DATE OF DEATH Month Jan. Day 12 Year 1968 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 1/23/1911 | | 9. AGE (In years last birthday) yrs. 56 | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer | | | 10b. KIND OF BUSINESS OR INDUSTRY 188-09-5326 | | 11. BIRTHPLACE (County & State, or foreign country) Waynesboro Pa., #2 | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME John Wishard | | | | 14. MOTHER'S MAIDEN NAME Maggie Duffey | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No | | 16. SOCIAL SECURITY NO. 188-09-5326 | | 17. INFORMANT Address Hagerstown Md. Mrs. Lillian Wishard, 1424 Jefferson Blvd. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Atrophy DUE TO (b) Cerebral Thromboses DUE TO (c) Arteriosclerotic Cardiovascular Disease 4129 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 4221 | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 2 yrs. 2 yrs. 5 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral Pneumonia. | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-5 , 19 68 , to 1-12 , 19 68 , that (I) (we) lost saw the deceased alive on 1-12 19 68 and that death occurred at 11:00 A.M. from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Charles E. Hess | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 1-13-68 | |
| 22c. PHYSICIAN'S NAME (Type) Charles Hess | | | | 22d. ADDRESS Smithsburg Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 1/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY Green Hill | | 23d. LOCATION (City or Town) (County) (State) Waynesboro Franklin Pa. | |
| 24. FUNERAL DIRECTOR Walter F. Howe | | | | ADDRESS Waynesboro Pa. | | 25a. REC'D BY REGISTRAR DATE JAN 17 1968 | |
| 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|--|--|--|---|--|----------------------------|---|-------|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Maurice Edgar Wolf | | | | | | Month Day Year | | 4:30A | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | 7. UNDER 1 YEAR | IF UNDER 24 HRS. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| Male | White | April 21, 1916 | 51 YRS | 8 MONTHS | 14 DAYS | January 10 1968 | | 5:00A | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Wolfsville, Md. | | U. S. A. | | | | Washington | | Md. | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | | Washington Co. Jail | | | Brick Mason | | Construction | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Boonsboro | | Rfd. 1 | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Loy Wolf | | | Nettie Kline | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| No. | | | 214-09-4981 | | Mr. Richard M. Wolf, Middletown Rfd., 1, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Congestion & Edema</u> 4129 DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Atherosclerosis, Severe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cardiac Hypertrophy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fatty Change Of Liver</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 hours Several years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 1-11-68 | | | |
| Dr. E. W. Ditto, Jr. | | | 215 W. Washington St., Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 1- 13- 68 | Wolfsville Cemetery | | Wolfsville, Fred. Md. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | JAN 16 1968 | | Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|-------------------------------------|--|--|---|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Ralph | | | | First S. Middle Wolfe Last Sr. | | | | 2a. DATE OF DEATH Month January Day 3 Year 1968 | | 2b. HOUR M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH November 14, 1887 | | 6. AGE (In years last birthday) 80 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 520 E. Wilson Blvd. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Printer, Retired | | | 12b. KIND OF BUSINESS OR INDUSTRY Newspaper | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY Washington | | 13c. CITY OR TOWN Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER 520 E. Wilson Blvd. | | |
| 14. FATHER'S NAME First Franklin Middle ? Last Wolfe | | | | 15. MOTHER'S MAIDEN NAME First Frances Middle ? Last Wiles | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No | | | | 16b. SOCIAL SECURITY NO. ----- | | 17. INFORMANT Mrs. Laura B. Wolfe | | | | Address 520 E. Wilson Hagerstown, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201 (b) Coronary atherosclerosis, severe DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Twice 25-30y " " | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Prostate hypertrophy, Benign | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar 8, 1967 , to Jan 4, 1968 , that (I) (we) last saw the deceased alive on Dec 10, 1967 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Edward W. Ditto DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/5/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Edward W. Ditto 3 rd. | | | | 22e. ADDRESS 217 W. Washington St. Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION | | 23b. DATE Jan. 8, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery | | 23d. LOCATION (City or Town) (County) (State) Middletown, Fred. Md. | | | | | |
| 24. FUNERAL DIRECTOR Gladhill Co. Middletown, Md. | | | | 25a. REC'D BY REGISTRAR JAN 9 1968 | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| 01783 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | Item 2 Film 6397 1/24/68 1K | | 01774 | |
|--|----------------------------------|---|-------------------------------------|--|--|---|---|
| CERTIFICATE OF DEATH | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE | | c. LENGTH OF STAY IN It 10 YRS. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAUGANSVILLE Hagerstown | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MAUGANSVILLE MENNONITE HOME | | | | d. STREET ADDRESS 1361 Jefferson Blvd. MAUGANSVILLE MENNONITE HOME <input type="checkbox"/> IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES | | | |
| 3. NAME OF DECEASED (Type or print) First GEORGE Middle POE Last WOLFINGER | | | | 4. DATE OF DEATH Month JANUARY Day 12 Year 1968 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3/7/1883 | 9. AGE (In years last birthday) 84 yrs. | IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. | | IF UNDER 24 HRS. Hours 1 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER | | 10b. KIND OF BUSINESS OR INDUSTRY OWN FARM | | 11. BIRTHPLACE (County & State, or foreign country) MARYLAND | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME ALEXANDER M. WOLFINGER | | | | 14. MOTHER'S MAIDEN NAME SOPHIA JANE LAMBERT | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO | | 16. SOCIAL SECURITY NO. 220-16-3330 | | 17. INFORMANT Address HAGERSTOWN MD. MISS BARBARA J. WOLFINGER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4129 <i>Cardiac Arrested</i> DUE TO <i>Coronary Arteriosclerosis</i> (b) <i>Myocardial Infarction</i> DUE TO <i>Myocardial Infarction</i> (c) <i>Myocardial Infarction</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 years <i>10 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4221 | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 2-1-68 to 1-12-68 , that (I) (we) last saw the deceased alive on 1-2-68 , and that death occurred at 1:30 PM , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>W. J. Norman</i> | | 22b. ADDRESS <i>21 W. Washington St. Hagerstown Md.</i> | | 22c. PHYSICIAN'S NAME (Type) W. J. Norman | | 22d. DATE SIGNED 1/13/68 | |
| 23a. BURIAL, CREMATION, REMAINS (Specify) BURIAL | | 23b. DATE THEREOF 1/15/68 | | 23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM. | | 23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD. | |
| 24. FUNERAL DIRECTOR W. J. Norman, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR DATE JAN 18 1968 | | 25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i> | |

CERTIFICATE OF DEATH

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|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>PA.</u> b. COUNTY <u>BEDFORD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HOPEWELL, PA.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON CO. HOSP.</u> | | d. STREET ADDRESS | |
| 3. NAME OF DECEASED (Type or print) First <u>Evan</u> Middle <u>Worthing</u> Last <u>Worthing</u> | | 4. DATE OF DEATH Month <u>Jan</u> Day <u>25</u> Year <u>1968</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-10-1876</u> |
| 9. AGE (In years lost birthday) yrs. <u>91</u> | | 10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>PA.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>THOMAS WORTHING</u> | | 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>185-30-3874</u> | |
| 17. INFORMANT <u>ROBERT WORTHING</u> | | Address <u>RFD #1 SCRANTON, PA.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Nephrosclerosis</u> DUE TO (c) <u>?</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>? years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>442x</u> <u>Congestive heart failure</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) this hospital attended the deceased from <u>Jan 11</u> , 19 <u>68</u> to <u>Jan 25</u> , 19 <u>68</u> , that (1) we last saw the deceased alive on <u>Jan 24</u> , 19 <u>68</u> and that death occurred at <u>5:00 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>M.E. Byrkit</u> | | 22b. DATE SIGNED <u>Jan 25, 1968</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>M.E. Byrkit</u> | | 22d. ADDRESS <u>Williamsport Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>1-28-68</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>REFORMED</u> | 23d. LOCATION (City or Town) (County) (State) <u>YELLOW CREEK BEDFORD, PA.</u> |
| 24. FUNERAL DIRECTOR <u>J.M. Lininger</u> | | ADDRESS <u>Mercersburg, Pa.</u> | |
| 25a. REC'D BY REGISTRAR DATE <u>JAN 29 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH Month Day Year | | | 2b. HOUR M |
| Myrtle | | | Viola Zimmerman | | | Jan. 13, 1968 | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS |
| Female | | White | | Feb. 26, 1905 | | | 62 YRS. | | IF UNDER 24 HRS. HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Washington, Maryland Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | 453 W. Antietam St. | | | House Work | | | Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER |
| Maryland | | | Washington | | | Hagerstown | | YES | 453 W. Antietam St. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Joseph Mummert | | | Elizabeth Widmyer | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | |
| No | | | None | | | 12 East Baltimore St Alvin S. Zimmerman Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Anoxia</u> <u>4409</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Pulmonary Edema</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis</u> | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>hour</u> <u>years</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4500</u> <u>None</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 19 <u>67</u> , to <u>13 Jan</u> , 19 <u>68</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>10 Jan</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>W. E. Wilson</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/15/68</u> | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 1/16/68 | | Shanktown, Cemetery | | Near Big Pool Md | | | |
| 24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc. Hagerstown, Md. | | | | | | 25a. REC'D BY REGISTRAR DATE JAN 17 1968 | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

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